(1)
Supreme Court, U.S.
FILED
00-863 SEP 12 2000
OFFICE OF THE CLERK

NO: _____

IN THE SUPREME COURT OF THE UNITED STATES

FRANKLIN J. DAY, M.D.,
Petitioner,
vs.

SUPERIOR COURT, THE
STATE OF CALIFORNIA,
SAN FRANCISCO COUNTY,
Respondent,

DIVISION OF MEDICAL
QUALITY OF THE MEDICAL
BOARD OF CALIFORNIA,
Real Party in Interest. /

ON PETITION FOR WRIT OF CERTIORARI TO THE STATE OF CALIFORNIA, FIRST APPELLATE DISTRICT

PETITION FOR WRIT OF CERTIORARI

JOHN T. SCHREIBER
Counsel of Record
LAW OFFICES OF JOHN T. SCHREIBER
961 Ygnacio Valley Road
Walnut Creek, California 94596
(925) 838-2460

306PP

QUESTIONS PRESENTED

1. Whether the Due Process Clause of the 14th Amendment to the United States Constitution is violated when a trial judge hearing a petition for administrative mandamus failed to read the entire administrative record before it.
2. Whether California Business & Professions Code § 2337, which restricts appellate review of trial court decisions revoking or otherwise limiting a physician's license to practice medicine in that State to petitions for extraordinary relief, violates the Equal Protection Clause of the 14th Amendment to the United States Constitution on the grounds that it unduly treats the physicians and surgeons differently from the many other licensed professionals who seek judicial review of administrative decisions pursuant to California Code of Civil Procedure § 1094.5.
3. Whether a state professional licensing board has jurisdiction over or can bring disciplinary charges against a licensee who is called to active duty with the United States Navy.
4. Whether a state professional licensing board violates a licensee's 14th Amendment due process rights by imposing discipline for conduct not alleged against him.

TABLE OF CONTENTS

QUESTIONS PRESENTED i

OPINIONS BELOW 1

JURISDICTION 1

CONSTITUTIONAL, STATUTORY and REGULATORY PROVISIONS INVOLVED 1

STATEMENT 2

REASONS FOR GRANTING THE PETITION 9

1. **The Appellate Court decision left standing by the California Supreme Court conflicts with numerous federal and state authorities that hold that the failure of a trial judge to examine the entire administrative record violated Petitioner's due process rights under the Fourteenth Amendment** 9

2. **The Landau decision upholding the 1995 amendment to California Business & Professions Code § 2337 against an equal protection challenge conflicts with this Court's holdings that the government interest a statute seeks to further must be an articulated, legitimate purpose.** 23

3. **The District Court of Appeal's decision leaving intact the trial court's finding that the Medical Board had disciplinary jurisdiction over DR. DAY while he was on active duty in the Navy without disciplinary action imposed by the Navy conflicts with this Court's holding in Solorio.** 26

4. **REAL PARTY could not discipline DR. DAY for matters not alleged in writing in the accusation against him.** .. 29

CONCLUSION 30

TABLE OF AUTHORITIES

CASES

Anderson v. Dewey,
350 P.2d 734, 737 (Idaho 1960) 17

Anderson v. Liberty Lobby, Inc.,
477 U.S. 242, 247-252,
106 S.Ct. 2505, 2509-2511 (1986) 19

Arrow-Hart, Inc. v. Philip Carey Co.,
552 F.2d 711, 712-713 (6th Cir. 1977) 15

Bail Bonds by Marvin
Nelson, Inc. v. CIR,
820 F.2d 1543, 1547
(9th Cir. 1987) 16

Barber v. Long Beach
Civil Service Com'n,
45 Cal.App. 4th 652, 658-659,
53 Cal.Rptr.2d 4, 8-9 (Cal.App. 2nd Dist. 1996) .. 19

Beizer v. Department of Labor,
742 A.2d 821, 828 (Conn.App. 2000) 13

Bixby v. Pierno
4 Cal.3d 130, 143-144 and
fn 10, 93 Cal.Rptr. 234, 243 (1971) 5,6,9,12,18

Bloom v. Municipal Court,
16 Cal.3d 71, 74-75,
127 Cal.Rptr. 317, 319,

545 P.2d 229 (1976) 23

Bradford v. Foundation
& Marine Constr. Co.,
182 So.2d 447, 449-450 (Fla.App. 1966) 17

Burns v. Wilson,
346 U.S. 137, 140,
73 S.Ct. 1045, 1048,
97 L.Ed. 1508 (1953) 27

Canseco v. U.S.,
97 F.3d 1224, 1227 (9th Cir. 1996) 14

Chung v. Dept. of Consumer & Reg. Affairs,
751 A.2d 989, 991 (D.C. 2000) 13

City of Greenville v. South
Carolina Second Injury Fund,
528 S.E.2d 91, 93 (S.C.App. 2000) 13

Collins v. City of Harker Heights, Tex.,
503 U.S. 115, 125,
112 S.Ct. 1061, 1171
L.Ed.2d 261 (1992) 10

Conn v. Gabbert,
526 U.S. 286, 291,
119 S.Ct. 1292,
143 L.Ed.2d 399 (1999) 11,26

Dent v. West Virginia,
129 U.S. 114, 9 S.Ct. 231,
32 L.Ed. 623 (1889) 11

Dickerson v. U.S., __U.S. __,
120 S.Ct. 2326, 2332-2335,
147 L.Ed.2d 405 (2000) 16

Drummey v. State Bd. of Funeral Directors
13 Cal.2d 75, 87 P.2d 848 (Ca. 1939) 7

Ettinger v. Board of
Medical Quality Assurance,
135 Cal.App.3d 853, 856,
185 Cal.Rptr. 601 (Cal.App.2d Dist. 1982) 18

European Beverage Co., Inc.
v. Superior Court (1996)
43 Cal.App. 4th 1211, 1214-1215,
51 Cal.Rptr.2d 147 17

Exxon Corp. v. United States,
931 F.2d 874, 878 (Fed. Cir. 1991) 14

Fahmy v. Medical Board of California,
38 Cal.App. 4th 810, 818,
45 Cal.Rptr.2d 486, 490-491 (1995) 20

Federal Deposit Insurance Corp. v Siraco,
174 F.2d 360 (2nd Cir. 1949) 15

Gardner v. Com'n
on Professional Competence,
164 Cal.App.3d 1035, 1038,
210 Cal.Rptr. 795, 797, fn. 2
(Cal.App 4th Dist. 1985) 18

Gates v. Department of Motor Vehicles,
94 Cal.App.3d 921, 156 Cal.Rptr. 791 (1979) 20

Griffin v. State of Illinois,
351 U.S. 12, 18, 76 S.Ct. 585, 590,
100 L.Ed. 891 (1956) 24

Guardianship of Sullivan (1904)
143 Cal. 462, 467, 77 P. 153 16

Harlow v. Carleson,
16 Cal.3d 731, 735,
129 Cal.Rptr. 298,
548 P.2d 698 (1976) 19

Home Placement Service v.
Providence Journal Co.,
819 F.2d 1199, 1202 & fn. 4
(1st Cir. 1987) 15,16

Huffman v. Lundquist
51 Ca.2d 465, 473,
234 P.2d 34 (1951) 21

In re Commission's
Investigation of PNMGS,
998 P.2d 1198, 1200 (N.M. 2000) 12

In re Higginbotham,
917 F.2d 1130, 1132 (8th Cir. 1990) 16

In re Ruffalo,
390 U.S. 544, 551,
S.Ct. 1222,

20 L.Ed.2d 117 (1968) 29,30

In re the Life and Fire Ins. Co. of
New York v. the Heirs of Wilson,
8 Pet. 291,
8 L.Ed. 949 (1834) 18

INS v. Cardoza-Fonseca,
480 U.S. 421, 432, 107 S.Ct. 1207, 1213,
94 L.Ed.2d 434 (1987) 25

Jordan v. Civil Service Bd.,
528 S.E.2d 927, 929
(N.C.App. 2000) 13

Kerr v. United States Dist. Ct.,
426 U.S. 394, 403,
96 S.Ct. 2119, 2124 (1976) 24

Landau v. Superior Court
81 Cal.App.4th 191,
97 Cal.Rptr. 2d 657 (1998) 1,9,23,24,26

Leone v. Medical Bd. of California
22 Cal.4th 660, 94 Cal.Rptr. 2nd 61,67
995 P.2d 191 (Cal.2000) 1,8,9

Lever v. United States,
443 F.2d 350, 351 (2d Cir. 1971) 15

Malibu Mountains Recreation, Inc.
v. County of Los Angeles
67 Cal.App. 4th 359, 372,
79 Cal.Rptr.2d 25

(Cal.App.2nd Dist. 1998) 7

Majetich v. Westin,
276 Cal.App.2d 216, 220,
80 Cal.Rptr. 787 (1969) 22

Marbury v. Madison (1803)
5 U.S. (1 Cranch) 137, 175-178 5

Mergentime Corp. v. WMATA,
166 F.3d 1257, 1262-1265
(D.C. Cir. 1999) 14,15

Meyer v. Nebraska
262 U.S. 390, 399, 43 S.Ct. 625,
67 L.Ed. 1042, (1923) 11

Milbrew v. CIR,
710 F.2d 1302, 1308 (7th Cir. 1983) 15

Morgan v. United States
298 U.S.468, 481,
56 S.Ct. 906,
80 L.Ed. 1288 (1936) 10,12,13,16,17

Nering v. Stockstill,
448 N.E.2d 695,
696-697 (Ind.App. 1983) 17

Norden v. Water Resources Dept.,
996 P.2d 958, 962 (Or. 2000) 13

O'Callahan v. Parker,
395 U.S. 258,

89 S.Ct. 1683,
23 L.Ed.2d 291 (1969) 27,28

Olsten Health Serv.
v. Arkansas Health,
12 S.W.3rd 656, 660 (Ark. App. 2000) 13

Omaha Indem. Co. v. Super. Ct.,
209 Cal.App.3d 1266, 1271,
258 Cal.Rptr. 66
(Cal.App.2d Dist. 1989) 24

Rex Oil, Ltd. v. M/V Jacinth,
873 F.2d 82, 87-88 (5th Cir. 1989),
cert. denied, 493 U.S. 1043,
110 S.Ct. 836, 107 L.Ed.2d 832 (1990) 15,16

Ross v. Moffitt,
417 U.S. 600, 616,
94 S.Ct. 2437, 2447, 41 L.Ed.2d 341 (1974) 24

St. Joseph Stockyards
Co. v. United States
298 U.S. 38, 49-52, 56 S.Ct. 720,
80 L.Ed. 1033 (1936) 7,10,12,16

Salve Regina College v. Russell
499 U.S. 225, 231-233,
111 S.Ct. 1217,
113 L.Ed.2d 190 (1991) 10

San Antonio Independent
School District v. Rodriguez,
411 U.S. 1, 17,

93 S.Ct. 1278, 1288,
36 L.Ed.2d 16 (1973) 26

Sherwin-Williams Co. v. Borchert
994 P.2d 959, 962-963
(Wyo. 1999) 12

Smith v. California
State Board of Pharmacy,
37 Cal.App. 4th 229, 243,
43 Cal.Rptr.2d 532 (1995) 30

Smith's Food King No. 1 v. Hornwood,
836 P.2d 1241, 1242-1243 (Nev. 1992) 17

Solario v. United States
483 U.S. 435, 107 S.Ct..2924,
97 L.Ed.2d 364 (1987) 5,6,26,27,28,29

State v. General Elec. Co.,
626 N.Y.S.2d 861, 862-863
(A.D. 3 Dept. 1995) 17

Stevens v. Hartford
Acc. and Indem. Co.
615 A.2d 507, 511 (Conn.App. 1992) 17

Sunshine v. Sunshine,
488 P.2d 1131,
1134 (Colo.App. 1971) 17

Townsend v. Gray Line Bus Co.,
767 F.2d 11, 18 (1st Cir. 1985) 15,16

U.S. Gypsum Co. v.
Schiavo Bros., Inc ,
668 F.2d 172, 175-177 (3rd Cir. 1981) 15

Watson Gravel, Inc. v. DMR
726 N.E.2d 1105, 1108
(Ohio App. 12 Dist. 1999) 13

Weigel v. Weigel,
591 N.W.2d 123, 125
(N.D. 1999) 17

Welsh v. Brown-Graves
Lumber Co.,
389 N.E.2d 514, 516
(Ohio App.9th Dist. 1978) 17

Whalen v. Ford Motor
Credit Co.,
684 F.2d 272, 278 (4th Cir.)(en banc),
cert. denied, 459 U.S. 910, 103 S. Ct. 216,
74 L.Ed. 2d 172 (1982) 15

Williams v. Williams
14th Cal.App.3d 560, 565,
92 Cal.Rptr. 385 9

Zand v. CIR Service,
143 F.3d 1393, 1400 14,15,16

STATUTES

United States

Constitution

Art. I, § 8, Cl. 14 1,27,28

Rules for the Government and Regulation of the land and naval Forces 27,28

14th Amendment 1,9,24

§ 1 1,24

the Due Process and Equal Protection Clauses of the Fourteenth Amendment 7,9,10,26

§ 1257(a) 1

Statutes

10 U.S.C. § 133 28

10 U.S.C.§ 5031 28

28 U.S.C. § 1257(a) 1

Federal Rules of Civil Procedure

Rule 63 1,10,13,14,15,16,17,22

Advisory committee's note (1991 Amendment) 15

Pre-1991 version of Rule 63 ... 15,17

California

Constitution 8

Art. VI, § 11 8,9

Business & Professions Code

§§ 2200, et seq. 23

§ 2305 29

§ 2337 1,7,8,23,24,25,26
1995 amendment 23,25

Code of Civil Procedure
§ 1094.5 1,23,24,25
§ 1094.5(c) 5,18

Department of Justice 26

Government Code
§ 11500 et seq. 23
Administrative Procedures Act ... 23
§ 11501 23,24
Medical Practices Act 23
60 enumerated agencies 24
§ 11503 30
§ 11523 23

Senate Bill
609 25,26
916 25
§ 25 25
Senate Bill 2375 in 1990 24
Senate Committee on Business and Professions .. 24

North Dakota
N.D.R.Civ.P. 17

REGULATIONS

32 Code of Federal Regulations
§ 721.6(j)(1) 26

TREATISES AND OTHER AUTHORITIES

Eisenberg, Horviz & Wiener,
Cal. Prac. Guide: Civil Appeals & Writs
(The Rutter Group 1999),
"Writs," ¶ 15:1,2 at 1522 23

12 James Wm. Moore,
Moore's Federal Practice, § 63.04[3] (1998) 14

PETITION FOR A WRIT OF CERTIORARI

Franklin J. Day, M.D., respectfully petitions for a writ of certiorari to review the opinion of the First District Court of Appeal, State of California, in this case.

OPINIONS BELOW

The opinion of the First District Court of Appeal (App. 1-9) is unpublished. The opinion of the First District Court of Appeal in Landau v. Superior Court (App. 208-259) is reported at 81 Cal.App.4th 191, 97 Cal.Rptr.2d 657(1998).

JURISDICTION

The California Supreme Court's order dismissing review of the First District Court of Appeal's decision was entered June 14, 2000 (App. 10). This Court has jurisdiction under 28 U.S.C. § 1257(a).

CONSTITUTIONAL, STATUTORY and REGULATORY PROVISIONS INVOLVED

The relevant portions of California Business & Professions Code § 2337, Code of Civil Procedure § 1094.5, Fed.R.Civ.P. 63, U.S. Const., Art. I, § 8, Cl. 14 and 14th Amendment, § 1, the Due Process and Equal Protection Clauses of the Fourteenth Amendment, U.S. Const are reproduced in the appendix to this petition (App. 202-205).[1]

---

[1] References to the Appendix to this Petition for Certiorari shall hereafter be referred to as "App. [page no]."

STATEMENT

DR. DAY has been a licensed California physician and surgeon since 1979. Since 1984 he has specialized in caring for the most difficult of non-malignant chronic pain patients. He had no prior disciplinary record (Petition for Administrative Mandamus, 1:5-9,[2] Appendix Exh. "A"). On or about February 2, 1994, REAL PARTY served an accusation on DR. DAY involving patient M.H., involving two causes of disciplinary action and eight separate allegations (Appendix Exh. "A", 1:16-17).

On February 24, 1994, the Navy began an investigation into DR. DAY's entire pain management practice at the Oak Knoll Naval Medical Center in Oakland, including his civilian practice. The review was specifically designed to address allegations of possible impairment of DR. DAY's professional judgment and knowledge base (Appendix Exh. "GG", Admin. Exh. 21).[3] The Navy used the preponderance of the evidence standard in its investigation(Exh. 25). DR. DAY was on active duty at the time (Appendix Exh. "GG", Exh. 21). Among the patients he treated in the course of events that were covered by the investigation was patient M.G., one of the patients at issue in this case (Appendix Exh. "FF", Admin. Hearing Transcript, Vol. 3, 84:11-19).[4] The

---

[2] References to the Appendix to the Petition for Mandamus, filed in the California First District Court of Appeal, Case No. A080131 shall hereafter be referred to as "Appendix Exh. "__".

[3] References to Appendix Exh. "GG", the Administrative Exhibits, shall hereafter be to " Exh."

[4] References to the Reporter's Transcript of the Administrative Hearings (Appendix Exh. "FF") shall hereafter be referred to by their individual volume

investigation found that there were not even any grounds to bring a case against DR. DAY with respect to M.G. (Vol. 15, 38:25-39:16, Vol. 22, 11:7-12:10, 12:21-13:19). DR. DAY was cleared by the Navy in July, 1994 and determined that his clinical privileges should be restored and his professional staff appointment continued (Exhs. "J","K").

On or about February 16, 1995, REAL PARTY filed a First Supplemental Accusation against DR. DAY, involving three patients, including M.G. for the same course of conduct DR. DAY was investigated for by the Navy (Vol. 3, 84:11-19, Vol. 15, 38:25-39:16, Vol. 22, 11:7-12:10, 12:21-13:19, Exh. "1").

On October 13, 1995 REAL PARTY filed its Second Supplemental Accusations against DR. DAY, involving two patients, A.C. and J.W. and two causes of disciplinary action (Appendix Exh. "W-15"). The administrative hearing was set for January 2, 1996 (Appendix Exh. "W-10").

On January 2, 1996 the administrative hearing in this case began (Vol. 1). During that entire time DR. DAY acted in pro per (Vol. 1, 4:3-17). The 22nd and last day of hearings was February 7, 1996 (Vol. 22).

On or about July 18, 1996, the ALJ filed his proposed Decision in the administrative matter. The ALJ ruled in DR. DAY's favor on approximately 80% of the accusations against him but found against DR. DAY on others, revolving on the self-injection issues [allowing patients to self-inject]; allowing non-malignant chronic pain patients to self-inject; prescribing methadone to patient M.H. on an as-needed basis; DR. DAY's placement of an infusion catheter at the thoracic level under general anesthesia without fluoroscopy as to patient B.C.; failing to develop a specific treatment plan as to patient M.G.; and for allowing patient A.C.'s minor son to provide the patient with

---

numbers, such as "Vol. 3."

Narcan, an anti-nausea medication (Appendix Exh."A"-1 (Proposed Decision), pp. 53-55).

REAL PARTY adopted the ALJ's decision as its own (Appendix Exh."A-1"). DR. DAY timely sought reconsideration of the decision. DR. DAY thereafter timely filed a petition for administrative mandamus in RESPONDENT COURT seeking review of the ALJ's decision (Appendix Exh."A").

DR. DAY alleged in his petition that REAL PARTY exceeded its jurisdiction over him in a number of different ways, *inter alia*, because he was on active duty in the military. DR. DAY also alleged that REAL PARTY abused its discretion by not proceeding in a manner authorized by law, the decision was not supported by the findings, and the findings were not supported by the evidence (Appendix Exh."A"). REAL PARTY filed its return (Appendix Exh."C"). DR. DAY filed a reply, including a declaration which contained a letter from one of his prospective counsel which stated that the counsel would be willing to represent DR. DAY if DR. DAY could obtain a continuance (Appendix, Exhs."D-I").

At the hearing on DR. DAY's writ petition the trial court acknowledged that further review of the record was necessary (Appendix Exh."E", 16:16-17, 17:21-26). Neither DR. DAY nor the Medical Board heard anything further from the court until early April 1997, when he received a cover letter from the California Attorney General's office enclosing a proposed statement of decision and an order after hearing (Appendix Exh."M", ¶ 4). A week after retaining post-trial and appellate counsel and filing objections to the proposed statement of decision, on April 29, 1997 DR. DAY went to the court house to review his file. He found that 17 of the 22 volumes of transcripts of the administrative hearing were still sealed and therefore unreviewed (Appendix Exh."M", ¶ 6). DR. DAY returned to the court room the following week and took photographs of those transcripts, both opened and unopened

(Appendix Exh."M", ¶ 8, Exhs."B" through "M"). The timely filed new trial motion followed. (Appendix Exh."K").

On June 16, 1997, RESPONDENT filed the Statement of Decision (Appendix Exh."I"). REAL PARTY served notice of entry three days later (Appendix Exh."J"). The Statement of Decision was the same as the proposed Statement of Decision and its findings are identical to the ALJ's proposed Decision (Appendix, Exhs."G, I").

On July 7, 1997, DR. DAY filed his notice of intent to move for new trial (Appendix Exh."K") then timely filed his points and authorities and declaration in support of his new trial motion. DR. DAY argued that RESPONDENT COURT failed to properly exercise its independent judgment on the administrative record before it as required under C.C.P. § 1094.5(c) and Bixby v. Pierno (1971) 4 Cal.3d 130, 143-144 and fn 10, 93 Cal.Rptr. 234, 243. In so doing DR. DAY traced the basis for requiring a trial court to review the entire administrative record back to the principle of judicial review meant to preserve constitutional rights, whether individual or minority, from obliteration by the majority. Marbury v. Madison (1803) 5 U.S. (1 Cranch) 137, 175-178. See also Bixby, supra, 4 Cal.3d at 141(Appendix Exhs. L, M).

DR. DAY also argued that RESPONDENT COURT's decision was against law in several respects: RESPONDENT COURT failed to rule on a jurisdictional issue raised by DR. DAY in his administrative mandamus petition below, whether REAL PARTY exceeded its jurisdiction by instituting disciplinary proceedings against DR. DAY while he was on active duty in the Navy, citing Solorio v. United States, 483 U.S. 435, 107 S.Ct. 2924, 97 L.Ed.2d 364 (1987). DR. DAY also argued that REAL PARTY violated his due process rights by imposing disciplinary action on him for matters not alleged in the accusations against him (Appendix Exh."L").

REAL PARTY filed its opposing points and authorities and declaration, arguing *inter alia* that RESPONDENT COURT completely reviewed the administrative record, that even if it did not, it was not necessary to do so and that REAL PARTY had jurisdiction to take disciplinary action against DR. DAY for his treatment of patient M.G., whose treatment took place while DR. DAY was in the Navy (Appendix Exhs."O," "P").

DR. DAY filed his reply points and authorities in support of his new trial motion. DR. DAY argued in pertinent part that photographs he took and which were attached as an exhibit to his declaration in support of his new trial motion belied REAL PARTY's contention that RESPONDENT COURT reviewed the entire administrative record; that Bixby, among other cases, required RESPONDENT COURT to review the entire administrative record in exercising its independent judgment; and that Solorio, supra. precluded REAL PARTY from bringing disciplinary action against DR. DAY while he was on active duty, since the basis for constitutional authority relied on in Solorio does not distinguish between criminal and non-criminal disciplinary interests and regulations (Appendix, Exhs."T").

On August 12, 1997 RESPONDENT COURT heard DR. DAY's new trial motion. RESPONDENT COURT denied the motion, admitting at the hearing that the COURT did not feel that it was necessary to review the entire administrative record to exercise its independent judgment (Appendix Exh."U", 3:13-4:2, 15:22-16:6). On that day, RESPONDENT COURT entered an order denying DR. DAY's motion for new trial (Appendix Exh."V").

DR. DAY then filed a petition for writ of mandamus in California's First District Court of Appeal, Div. 3, Case No. A080131, based inter alia, on the following issues: the trial court's failure to exercise its independent judgment based on failing to review the entire administrative record; REAL PARTY'S lack of jurisdiction over DR. DAY under Solorio

because DR. DAY was on active duty in the Navy while the MEDICAL BOARD brought charges against him; that California's Business & Professions Code § 2337 violated both California's and the Fourteenth Amendment's Equal Protection Clauses; and that the MEDICAL BOARD disciplined DR. DAY for matters not alleged in writing against him (Petition for Writ of Mandate, pp. 25-67).

The First District requested opposition from the MEDICAL BOARD only on the independent judgment issue. The MEDICAL BOARD did so, arguing that the trial court considered all evidence cited to it by DR. DAY and that the trial court did not actually have to read everything to exercise its independent judgment. In so arguing, the MEDICAL BOARD relied largely on Drummey v. State Bd. of Funeral Directors, 13 Cal.2d 75, 87 P.2d 848 (Cal. 1939), quoting portions of the Drummey that established the principle that a trial court reviewing a quasi-judicial administrative decision involving a license disciplinary proceeding brought by a state agency must exercise "its independent judgment on the facts, as well as on the law, if the complaining party is to be accorded his constitutional rights under the state and federal Constitutions"(Supp. Opp. At 11-12 (citing Drummey, supra, 13 Cal.2d at 84, 87 P.2d at 853)) and quoting another portion of Drummey that referred to St. Joseph Stock Yards Co., 298 U.S. 38, 56 S.Ct. 720, 80 L.Ed. 1033 (1936) and later asserted that substantial evidence supported the administrative decision, relying on Malibu Mountains Recreation, Inc. v. County of Los Angeles, 67 Cal.App.4th 359, 372, 79 Cal.Rptr.2d 25 (Cal.App.2nd Dist. 1998) to show that due process was met (Supp. Opp. at 17).

A little over a month after DR. DAY filed his reply, the First District denied DR. DAY's writ petition by an unpublished opinion (App. 1-8). The opinion only addressed the independent judgment issue (Ibid) and held that since Drummey places the burden of persuasion on the petitioner in an administrative

mandamus proceeding, it is the petitioner's obligation to convince the court that the administrative decision is contrary to the weight of the evidence (App. at 5).

The opinion stated that "[t]he key to our decision is the distinction between 'reading' and 'reviewing.' In order to 'review the whole record' it is not strictly necessary to read every word, as long as the petitioner has directed the attention of the court to those material portions of the record he or she contends undermine the administrative decision."(App. 7) The court held that since DR. DAY cited to particular parts of the record in his trial court petition and attached copies of many of those portions in an appendix to his petition that it was unnecessary for the trial court "to open all the actual reporters' transcripts of the administrative record in order to peruse the citations on which petitioner was relying" (App. 8).

DR. DAY petitioned the California Supreme Court for review, focusing primarily on the constitutionality of Business & Professions Code § 2337 (Pet'n for Review at 11-15) and the independent judgment issue (Pet'n for Review at 15-25). Among the grounds DR. DAY asserted in the independent judgment portion of the document was that failure to so exercise was a violation of due process, analogizing to a trial judge in a non-jury trial who enters judgment without hearing all the evidence (Pet'n for Review at 22)and that the 1st District decision misunderstood the role of the trial court in such instances to be akin to an appellate court instead of its function as the trier of fact (Pet'n for Review at 21-22).

The California Supreme Court granted review on a "grant and hold" basis, because another case, Leone v. Medical Board, was before the Court on a related issue (the constitutionality of B&P § 2337 under the California Constitution) and deferred briefing and consideration of the other issues pending resolution in Leone (App. 11). In April 2000, the California Supreme Court upheld the constitutionality of § 2337 under Art. VI, § 11 of the

California Constitution and remanded the matter back to the Second District Court of Appeal for consideration of due process and equal protection arguments. Leone v. Medical Bd., 22 Cal.4th 660, 94 Cal.Rptr.2d 61, 67, 995 P.2d 191 (Cal. 2000).

On June 14, 2000, the California Supreme Court dismissed review in this case, the same day that the California Supreme Court dismissed review in Landau and directed publication of the First District's opinion in that case (App. 10, 206-207).

REASONS FOR GRANTING THE PETITION

1. The Appellate Court decision left standing by the California Supreme Court conflicts with numerous federal and state authorities that hold that the failure of a trial judge to examine the entire administrative record violated Petitioner's due process rights under the Fourteenth Amendment.

The First District Court of Appeal's Opinion below held that a trial court met its duty to exercise its independent judgment on the entire administrative record before it in a proceeding challenging an administrative finding even though the trial judge did not even unseal 17 of the 22 volumes of transcripts of the administrative hearing, let alone review them (App. 4-5). See Bixby v. Pierno (1971) 4 Cal.3d 130, 143-144 & fn. 10. The Opinion stated that "[t]he key to our decision is the distinction between 'reading' and 'reviewing'"(App. at 7).

In so holding the appellate court relied on Williams v. Williams, 14 Cal.App.3d 560, 565, 92 Cal.Rptr. 385 for the proposition that "[i]t is incumbent upon the parties to an appeal to cite the particular portion of the record supporting each assertion made. It should be apparent that a reviewing court has no duty to search through the record to find evidence in support of a party's position." Williams, supra (App. 7). This language states the

parties' duty in an appeal to cite the particular portion of the record. The court's reliance on this language shows their confusion about the differing roles of a trial and appellate court. Those roles are very different. Appellate courts generally only decide questions of law. Resolution of factual issues is best left to the trial courts. Salve Regina College v. Russell, 499 U.S. 225, 231-233, 111 S.Ct. 1217, 113 L.Ed.2d 190 (1991).

The trial court's failure, upheld by the appellate court, violated Petitioner's due process rights under both this Court's time-honored precedents requiring meaningful judicial review of administrative decisions (Morgan v. United States, 298 U.S. 468, 481, 56 S.Ct. 906, 80 L.Ed. 1288 (1936)("[t]he one who decides must hear"), St. Joseph Stock Yards Co. v. United States, 298 U.S. 38, 49-52, 56 S.Ct. 720, 80 L.Ed. 1033 (1936)) and those of federal and state courts across this country. The effect of what the trial court did in this case is analogous to a trial judge deciding a trial without having heard the evidence. Federal Rule of Civil Procedure 63 and case law interpreting that Rule protects against such a result, in part on constitutional grounds, as do numerous cases, rules, and statutes in state courts nationwide. This state court therefore decided an important federal question in a way that conflicts with the decisions of this Court, other state courts of last resort and several United States courts of appeals.

The purpose of the Due Process Clause of the 14th Amendment is "to prevent government 'from abusing [its] power, or employing it as an instrument of oppression.'" Collins v. City of Harker Heights, Tex., 503 U.S. 115, 126, 112 S.Ct. 1061, 117 L.Ed.2d 261 (1992). "[T]he liberty guaranteed by the Fourteenth Amendment " 'denotes not merely freedom from bodily restraint but also the right of the individual to contract, to engage in any of the common occupations of life, to acquire useful knowledge, to marry, establish a home and bring up children, to worship God according to the dictates of his own conscience, and generally to enjoy those privileges long recognized ... as essential to the

orderly pursuit of happiness by free men.' " Conn v. Gabbert, 526 U.S. 286, 291,119 S.Ct. 1292, 143 L.Ed.2d 399 (1999)(quoting Meyer v. Nebraska, 262 U.S. 390, 399, 43 S.Ct. 625, 67 L.Ed. 1042, (1923)). That right is subject to reasonable government regulation. Dent v. West Virginia, 129 U.S. 114, 9 S.Ct. 231, 32 L.Ed. 623 (1889) (upholding a requirement of licensing before a person can practice medicine).

Although an administrative agency's findings come to a court with a "strong presumption in favor of the conclusions reached by an experienced administrative body after a full hearing",

> to say that their findings of fact may be made conclusive where constitutional rights of liberty and property are involved, although the evidence clearly establishes that the findings are wrong and constitutional rights have been invaded, is to place those rights at the mercy of administrative officials and seriously to impair the security inherent in our judicial safeguards. That prospect, with our multiplication of administrative agencies, is not one to be lightly regarded. It is said that we can retain judicial authority to examine the weight of evidence when the question concerns the right of personal liberty. But, if this be so, it is not because we are privileged to perform our judicial duty in that case and for reasons of convenience to disregard it in others. The principle applies when rights either of person or of property are protected by constitutional restrictions. Under our system there is no warrant for the view that the judicial power of a competent court can be circumscribed by any legislative arrangement designed to give effect to administrative action going beyond the limits of constitutional authority.

St. Joseph's Stockyards, supra, 298 U.S. at 52, 53. Yet the state court ruling at issue here effectively does just that. The trial court's failure to even open, let alone review the 17 of 22 volumes of administrative hearing transcripts (Appendix Exh."M", ¶ 8, Exhs."B" through "M") meant that the trial court was deciding the matter without reviewing all of the evidence before it.

As this Court stated in Morgan, supra:

> It is no answer to say that the question for the court is whether the evidence supports the findings and the findings support the order. For the weight ascribed by the law to the findings--their conclusiveness when made within the sphere of the authority conferred--rests upon the assumption that the officer who makes the findings has addressed himself to the evidence, and upon that evidence has conscientiously reached the conclusions which he deems it to justify. That duty cannot be performed by one who has not considered evidence or argument. It is not an impersonal obligation. It is a duty akin to that of a judge. The one who decides must hear.

Morgan, supra, 298 U.S. at 481.

Across this country state courts require the trier of fact to consider all of the record before them in reviewing an administrative decision. Bixby, supra, 4 Cal.3d at 143-144, 93 Cal.Rptr.234, 481 P.2d 242, fn.10; In re Commission's Investigation of PNMGS, 998 P.2d 1198, 1200 (N.M. 2000)(court looks to "the whole record" to determine whether substantial evidence supports agency findings); Sherwin-Williams Co. v. Borchert, 994 P.2d 959, 962-963 (Wyo. 1999) ("We must examine the entire record and consider conflicting and contradictory evidence to determine whether, in light of all the evidence before it, the hearing officer could have reasonably

concluded as it has in this case"); Watson Gravel, Inc. v. DMR, 726 N.E.2d 1105, 1108 (Ohio App. 12 Dist. 1999)("In making its determination, the court of common pleas must give consideration to the entire record and appraise the credibility of witnesses, the probative character of the evidence and the weight to be given it."); Olsten Health Serv. v. Arkansas Health, 12 S.W.3rd 656, 660 (Ark.App. 2000)(court reviews entire record to determine whether there is any substantial evidence and whether the decision was arbitrary or capricious); Norden v. Water Resources Dept., 996 P.2d 958, 962 (Or. 2000)(reviewing record "as a whole" to "consider all the evidence in the record"); Jordan v. Civil Service Bd., 528 S.E.2d 927, 929 (N.C.App. 2000)(the trial court must examine "all competent evidence (the 'whole record') in order to determine whether the agency decision is supported by substantial evidence); Beizer v. Department of Labor, 742 A.2d 821, 828 (Conn.App. 2000)("...record taken as a whole"); City of Greenville v. South Carolina Second Injury Fund, 528 S.E.2d 91, 93 (S.C.App. 2000)("In reviewing an agency order, this court 'may not substitute its judgment as to the weight of the evidence on questions of fact unless the agency's findings are clearly erroneous in view of the reliable, probative and substantial evidence on the whole record.' (Citations omitted) 'Substantial evidence' is evidence which, considering the record as a whole, would allow reasonable minds to reach the conclusion that the administrative agency reached.'"(citations omitted)); Chung v. Dept. of Consumer & Reg. Affairs, 751 A.2d 989, 991 (D.C. 2000)("This court will uphold an agency decision if it flows rationally from the facts and is supported by substantial evidence in the record as a whole(citations omitted).").

The analogy would be to a trial judge who renders judgment without hearing all the testimony and other evidence. Due process prohibits such a result. Morgan, supra. Federal and state authorities have adopted rules prohibiting a judge from doing so. Fed.R.Civ.Pro. 63 provides that:

> [i]f a trial or hearing has been commenced and the judge is unable to proceed, any other judge may proceed with it upon certifying familiarity with the record and determining that the proceedings in the case may be completed without prejudice to the parties. In a hearing or trial without a jury, the successor judge shall at the request of a party recall any witness whose testimony is material and disputed and who is available to testify again without undue burden. The successor judge may also recall any other witness.

Federal Circuit Courts of Appeal across this country construe FRCP 63 to require that for a successor judge to complete proceedings before him or her, the successor judge must certify his or her familiarity with the record by "read[ing] and consider[ing] all relevant portions of the record.". Canseco v. U.S., 97 F.3d 1224, 1227(9th Cir. 1996)(emphasis added); Mergentime Corp. v. WMATA, 166 F.3d 1257, 1262-1265(DC Cir. 1999)(relying on Canseco); Zand v. CIRService, 143 F.3d 1393, 1400; Exxon Corp. v. United States, 931 F.2d 874, 878(Fed.Cir. 1991); 12 James Wm. Moore, Moore's Federal Practice § 63.04[3](1998). That rule following its 1991 amendment even applies after the original judge made findings and entered judgment. Canseco, supra, 97 F.3d at 1226.

Rule 63 was amended in 1991, allowing a successor judge to take over at any time after trial begins, not just after the filing of findings of fact and conclusions of law. The growing length of federal trials increased the likelihood of a judge's inability to continue that would interrupt a trial before verdict or judgment. Mergentime, supra, 166 F.3d at 1262. The objective was to create a more "efficient mechanism" for completing interrupted trials without causing unnecessary expense and delay" yet avoiding the "injustice [that]... may result if the substitute judge

proceeds despite unfamiliarity with the action." Fed.R.Civ.Pro. 63 advisory committee's note (1991 Amendment).

The importance of this latter point is underscored by Rule 63's requirement that the successor judge must, at the request of a party, recall any witness whose testimony is material and disputed and who is available to testify again without undue burden.

The pre-1991 version of Rule 63 did not change the fact that the trial judge who makes the decision must be one who hears the case. Zand, supra, 143 F.3d at 1400("[A]lthough Rule 63 was amended in 1991 and considerably broadened, the present rule encompasses the former rule and more.... We therefore look to pre-1991 decisions for guidance given the facts of this case."). The pre-1991 Fed.R.Civ.P. 63 allowed a successor judge to enter judgment only after trial was complete and the original judge filed findings of fact and conclusions of law or on stipulation of the parties, based on due process concerns. Home Placement Service v. Providence Journal Co., 819 F.2d 1199, 1202 & fn.4 (1st Cir. 1987)(citing Townsend v. Gray Line Bus Co., 767 F.2d 11, 18 (1st Cir. 1985)). See also Federal Deposit Insurance Corp. v. Siraco, 174 F.2d 360 (2d Cir. 1949)(but cf. Lever v. United States, 443 F.2d 350, 351(2d Cir. 1971)(successor judge's decision permissible under FRCP 63 because the predecessor judge left elaborate findings of fact and evaluation of the credibility of the witnesses)); Whalen v. Ford Motor Credit Co., 684 F.2d 272, 278 (4th Cir.)(en banc), cert. denied, 459 U.S. 910, 103 S.Ct. 216, 74 L.Ed. 2d 172(1982); Arrow-Hart, Inc. v. Philip Carey Co., 552 F.2d 711, 712-713 (6th Cir. 1977); U.S. Gypsum Co. v. Schiavo Bros., Inc., 668 F.2d 172, 175-177(3rd Cir. 1981)(FRCP 63 not considered because the successor judge was ruling on legal conclusions involved in the motion for reconsideration before him, not on issues of disputed facts); Milbrew v. CIR, 710 F.2d 1302, 1308(7th Cir. 1983)(parties stipulate); Rex Oil, Ltd. v. M/V Jacinth, 873 F.2d 82, 87-88 (5th Cir. 1989), cert. denied, 493 U.S.

1043, 110 S.Ct. 836, 107 L.Ed.2d. 832(1990)(predecessor judge left existing findings of fact, conclusions of law); In re Higginbotham, 917 F.2d 1130, 1132 (8th Cir. 1990); Bail Bonds by Marvin Nelson, Inc. v. CIR, 820 F.2d 1543, 1547(9th Cir. 1987)(relying on Townsend, supra).

These Circuit cases also reveal conflict or uncertainty between the First and the other Circuits as to whether the principle set forth in FRCP 63 derives from constitutional principles of due process or is merely based on a rule itself. The 1st Circuit in Home Placement and Townsend stated that this rule derives from constitutional principles. 819 F.2d at 1202 and fn. 4; 767 F.2d at 18. The 11th Cir. in Zand, supra, 143 F.3d at 1400 likewise relies on Townsend. The other authorities listed above do not. In light of this Court's holdings in St. Joseph's Stock Yards and Morgan this Court can make clear the constitutional underpinnings of this rule, not unlike how this Court clarified the basis for the Miranda rule in this Court's prior term. Dickerson v. U.S., __U.S.__, 120 S.Ct. 2326, 2332-2335, 147 L.Ed.2d 405 (2000).

Numerous state court decisions arrive at a due process-based conclusion. In California,

> the law has long been settled that in a civil action "[a] party litigant is entitled to a decision upon the facts of his case from the judge who hears the evidence, where the matter is tried without a jury, and from the jury that hears the evidence, where it is tried with a jury. He cannot be compelled to accept a decision upon the facts from another judge or another jury." (Guardianship of Sullivan (1904) 143 Cal. 462, 467, 77 P. 153)....Where there has been an interlocutory judgment rendered by one judge, and that judge then becomes unavailable to decide the remainder of the case, a successor judge is obliged to hear the evidence

> and make his or her own decision on all issues, including those that had been tried before the first judge, unless the parties stipulate otherwise. (Citation omitted) This is because an interlocutory judgment is subject to modification at any time prior to entry of a final judgment. (Ibid.) It is considered a denial of due process for a new judge to render a final judgment without having heard all of the evidence. (Citation omitted).

European Beverage Co., Inc. v. Superior Court (1996) 43 Cal.App. 4th 1211, 1214-1215, 51 Cal.Rptr.2d 147. See also Stevens v. Hartford Acc. and Indem. Co., 615 A.2d 507, 511 (Conn.App. 1992)(relying on Morgan, supra, Fed.RCiv.P. 63); Weigel v. Weigel, 591 N.W.2d 123, 125 (N.D. 1999)(due process concerns, relying on Rule 63, N.D.R.Civ.P., identical to Fed.RCiv.P. 63); Anderson v. Dewey, 350 P.2d 734, 737 (Idaho 1960)(also relying on due process and their own identical version of Fed.RCiv.P. 63); State v. General Elec. Co., 626 N.Y.S.2d 861, 862-863 (A.D. 3 Dept. 1995); Bradford v. Foundation & Marine Constr. Co., 182 So.2d 447, 449-450 (Fla.App. 1966); Sunshine v. Sunshine, 488 P.2d 1131, 1134 (Colo.App.1971)(relying on own version of pre-1991 Fed.RCiv.P. 63); Welsh v. Brown-Graves Lumber Co., 389 N.E.2d 514, 516 (Ohio App.9th Dist. 1978); Smith's Food King No. 1 v. Hornwood, 836 P.2d 1241, 1242-1243 (Nev. 1992)(Under own identical version of pre-1991 Fed.R.Civ.P. 63 and under current version of Fed.R.Civ.P. 63 new trial was necessary, since predecessor judge became unavailable before entering conclusions of law and findings of fact and because the evidence was disputed and one of the parties requested a new evidentiary hearing); Nering v. Stockstill, 448 N.E.2d 695, 696-697 (Ind.App. 1983)(successor judge could rule on post-trial motions after reviewing transcripts and the record, including predecessor judge's findings and conclusions).

A very early decision of this Court, In re the Life and Fire Ins. Co. of New York v. the Heirs of Wilson, 8 Pet. 291, 8 L.Ed. 949 (1834) is consistent with the cases mentioned above. There the predecessor judge had already entered judgment but died before he could sign it after the prerequisite three day waiting period under Louisiana law. Wilson, supra, 8 Pet. at 303. This Court held that since judgment was already entered signing of the judgment under Louisiana law was a ministerial act without which no further proceedings could take place for a party to seek reversal of the judgment. 8 Pet. at 303-304.

Therefore the cases mentioned above either flatly prohibit a successor judge from ruling on a case prior to entry of findings of fact and conclusions of law or require the new trial judge to review all relevant evidence and testimony to certify or assure familiarity with the case before ruling. In this case and the many others in Petitioner's situation, review of all testimony in the transcripts was critical.

In California's medical disciplinary regime, the Medical Board must prove its case before the administrative law judge using a "clear and convincing proof to a reasonable certainty standard." Ettinger v. Board of Medical Quality Assurance, 135 Cal.App.3d 853, 856, 185 Cal.Rptr. 601(Cal.App. 2d Dist. 1982).

The trial court exercises its independent judgment on the entire administrative record. Bixby, supra; CCP § 1094.5(c). As part of its duty the trial court must make sure that the administrative law judge applied Ettinger's "clear and convincing evidence" standard. Gardner v. Com'n on Professional Competence, 164 Cal.App.3d 1035, 1038, 210 Cal.Rptr. 795, 797, fn. 2 (Cal.App.4th Dist. 1985). If the standard was not correctly applied, then the licensee is entitled to another administrative hearing. Gardner, supra. This rule applies even though the trial court applies the preponderance of the evidence test in exercising its independent judgment on the administrative record. Gardner, supra.

The trial court supplants the administrative agency as the trier of fact. Harlow v. Carleson, 16 Cal.3d 731, 735, 129 Cal.Rptr.298, 548 P.2d 698 (1976). As such, the trial court must weigh the evidence, including assessing the credibility of witnesses at the administrative hearing. Failure to do so is reversible error. Barber v. Long Beach Civil Service Com'n, 45 Cal.App. 4th 652, 658-659, 53 Cal.Rptr.2d 4, 8-9(Cal.App. 2 Dist. 1996).

In this case, for example, this issue was especially critical because there was conflicting expert testimony on both sides as to whether there was a standard of care in this newly-emerging and difficult area of medical practice and if so, whether DR. DAY's conduct conformed to that standard. A much stricter standard such as clear and convincing to reasonable proof of certainty is much harder for an agency to meet and requires much stronger and weightier evidence supporting its claims than in an ordinary civil case.

For example, the Navy cleared DR. DAY of any charges in an investigation of his pain management practice, including his civilian practice and his treatment of M.G. (Exhs."J", "K""GG", 21) using the preponderance of the evidence standard (Exh. 25). The Navy proceedings are also probative in that the Navy investigated charges that DR. DAY improperly placed a "thoracic subarachnoid catheter," the basis for charges brought against him involving patient B.C. (Exh. 1-First Supplemental Accusation ¶¶45K, L, Appendix Exh. "I", 28:3-31:4) and found DR. DAY's management of this procedure to be appropriate (Exhibit "J") using the same standard. An analogy would be to cases such as defamation suits governed by the actual malice standard, which require clear and convincing evidence to survive summary judgment motions, let alone show liability. Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 247-252, 106 S.Ct. 2505, 2509-2511 (1986).

In fact, the trial court stated that it would look at the record to resolve that issue (Appendix Exh."E", 17:17-22). The Day declaration and photographs make clear that an independent review did not occur.

Second, the failure to independently review the administrative record materially affected the court's ruling on the issue of the ALJ's denial of a continuance six weeks before the lengthy (22 days) hearing began on January 2, 1996 (Appendix Exh."C", Exh."H" thereto). The denial also took place a little over two weeks after the attorney general's office added two supplemental accusations as to patients A.C. and J.W. on October 13, 1995 (Id). The trial court expressed confusion and uncertainty with what the facts were with respect to this issue and stated that he had more reading to do (Appendix Exh."E", 15:13-16:19). The Day declaration and photographs make clear that the needed review did not take place.

The lack of an independent review also materially affected DR. DAY's laches claim. Laches requires an unreasonable delay causing prejudice to the opposing party. Gates v. Department of Motor Vehicles, 94 Cal.App.3d 921, 156 Cal.Rptr. 791 (1979). In Gates the appellate court upheld a finding of laches where, as a result of the total delay, the memories of witnesses had diminished to a point where RESPONDENT could not engage in effective cross- examination. Gates, supra, 94 Cal.App.3d at 925-926. Testimony showing patient AC's faded memory impeded Day's efforts at cross-examination (Vol. 4, 84:16-25, 94:1-5, 105:15-20). Even Fahmy v. Medical Board of California 38 Cal.App.4th 810, 818, 45 Cal.Rptr.2d 486, 490-491 (1995) recognized that prejudice exists in situations like those in Gates, like this case. Yet that volume of testimony, like 16 of the other 21 volumes, remained unread by the court (Appendix Exh."M", ¶¶6-9).

Failure to independently review the administrative record also critically impacted on the trial court's ability to review

whether there was a standard of care in this field and if so, whether DR. DAY breached that duty. In those contexts, expert testimony is the sole source of proof. Huffman v. Lundquist 51 Cal.2d 465, 473, 234 P.2d 34 (1951)(judgment of nonsuit in favor of medical malpractice defendant affirmed). A physician or surgeon is not responsible "for every untoward result which may occur in medical practice." Huffman, supra, 51 Cal.2d at 473 (citation omitted). ALJ Lew was therefore required to rely exclusively on expert testimony to decide on these two issues and had to do so in a case involving conflicting expert testimony on both sides.

Here the trial court could not have possibly reweighed the evidence and reviewed the credibility of the witnesses with 17 of the 22 volumes of transcripts unopened (Appendix Exh."M", ¶¶ 6-7, photographs). Credibility and weight of the evidence were very much at issue in this case (Appendix Exh."E", 6:7-7:6). There was a significant amount and degree of testimony by DR. DAY's experts and even by REAL PARTY's own experts showing the lack of qualifications, experience, and expertise of REAL PARTY's experts (Vol. 6, 7:4-6, 63:16-66:24, 79:10-14, 80:2-23, 87:3-6 (compare with documents sent to REAL PARTY expert Levin (Exh. 32)), 89:19-90:1, 91:14-25, 133:20-134:17, 176:10-177:16; Vol. 10,9:16-11:6, 101:19-21, 103:14-17, 114:11-115:10; Vol. 9, 60:11-63:3, 172:3-12, 152:24-161:10, 164:8-16, 167:5-7; Vol. 17, 100:23-101:23, 102:20-103:8, 136:23-137:1; Vol. 18, 23:3-24:16, 40:14-41:6, 44:11-45:12, 50:1-53:1, 134:21-135:2; Vol. 22, 75:10-80:17).

Lack of a consensus of a standard of care was significant in this case:

> Where there is more than one recognized method of diagnosis or treatment and no one of them is used exclusively or uniformly by all practitioners of good standing, a physician and surgeon is not negligent if, in exercising his best judgment, he

> selects one of the approved methods, which later turns out to be a wrong selection, or one not favored by certain other practitioners.

Majetich v. Westin, 276 Cal.App.2d 216, 220, 80 Cal.Rptr. 787(1969).

Numerous examples of expert testimony showing either the lack of consensus as to a standard of care within the field or that DR. DAY's practice met the standard where it existed were in unopened portions of the record:

a. Dr. Gruber's testimony that there is little consensus among pain practitioners as to how to approach treating chronic pain patients (Vol. 17, 100:23-101:23);

b. Dr. Snook's testimony regarding teaching patients how to self-inject (Vol. 18, 89:25-91:18);

c. Dr. Gruber's testimony that self-injection for chronic pain of non-malignant origin is practiced at a number of prestigious centers around the country and that the trend is toward treating pain as pain regardless of origin (Vol. 17, 96-98);

d. DR. DAY's patient Gwen Snow's testimony about her non-terminal pain and the relief brought her by self-injection, as well as her ability to teach self-injection techniques to others, including very young minors as part of her job as a nurse(Vol. 17, 5:1-12, 15:3-24:14); and

e. DR. DAY's cross-examination of REAL PARTY's expert Dr. Eisele on the issue of self-injection for patients by epidural catheter for chronic pain and the introduction into evidence for impeachment purposes of an article discussing self-injection for patients by epidural catheter for chronic pain (Vol. 10, 19:15-38:23, 55:23-56:13).

This Court has the opportunity to resolve the conflict in this matter between the Appellate Court opinion in this case and the numerous decisions at both the federal and state level that hold to the contrary. This Court also has the opportunity to resolve the uncertainty among the circuits as to whether FRCP 63

derives from constitutional principles. Postponing review will not greatly add to analysis of this issue. This Court has the opportunity by this case to state once and for all a trial court's duty in these circumstances.

2. The Landau decision upholding the 1995 amendment to California Business & Professions Code § 2337 against an equal protection challenge conflicts with this Court's holdings that the government interest a statute seeks to further must be an articulated, legitimate purpose.

California Business & Professions Code § 2337 is part of California's Medical Practices Act (California Business & Professions Code §§ 2000 et seq.), which regulates the practices of physicians, surgeons, and podiatrists, among other licensed medical professionals. California Administrative Procedures Act (California Government Code § 11500 et seq.) governs disciplinary proceedings brought by California's Medical Board against those subject to the Medical Practices Act. Gov. C. § 11501. Trial court review of those proceedings is available via petition for administrative mandamus. Gov. C. § 11523. California Code of Civil Procedure § 1094.5 addresses petitions for administrative mandamus.

Before the 1995 amendment to § 2337 took effect, anyone contesting a superior court decision arising from a petition for administrative mandamus could do so by appeal as of right. Bloom v. Municipal Court, 16 Cal.3d 71, 74-75, 127 Cal.Rptr. 317, 319, 545 P.2d 229 (1976). After the 1995 amendment to B&P § 2337, however, "review of the superior court's decision [revoking, suspending, or restricting a license] shall be pursuant to a petition for extraordinary writ." Appellate court review of extraordinary writs in California is completely discretionary. Eisenberg, Horvitz & Wiener, Cal. Prac. Guide: Civil Appeals & Writs (The Rutter Group 1999), "Writs," ¶ 15:1.2 at 1522. See

also Kerr v. United States Dist. Ct., 426 U.S. 394, 403, 96 S.Ct. 2119, 2124 (1976)("issuance of the writ is in large part a matter of discretion"). California appellate courts deny approximately 90% of petitions for extraordinary relief. Omaha Indem. Co. v. Super. Ct., 209 Cal.App.3d 1266,1271, 258 Cal.Rptr. 66 (Cal.App.2d Dist. 1989). No other profession subject to superior court review under CCP § 1094.5 has their right to direct appellate review so limited. See the sixty (60) enumerated agencies listed in Cal. Govt. Code § 11501.

The Fourteenth Amendment, § 1, of the United States Constitution protects against denial of equal protection of the laws. In this specific context, even though a state need not provide for a right to appeal, once it does so, it must give all persons an equal opportunity to pursue that right. Ross v. Moffitt, 417 U.S. 600, 616, 94 S.Ct. 2437, 2447, 41 L.Ed.2d 341 (1974); Griffin v. State of Illinois, 351 U.S. 12, 18, 76 S.Ct. 585, 590, 100 L.Ed. 891(1956). Though Ross and Griffin addressed whether a state must provide an indigent criminal defendant the right to appointed counsel for his or her appeal as of right and distinguished that right from the context of a petition for certiorari, the principle applies nonetheless. The statute provides other professions with the right to direct appeals. Having done so the statute must treat doctors the same way or have a sufficient reason for not doing so.

Section 2337 was originally enacted as part of Senate Bill 2375 in 1990 to reduce delays in the physician discipline process (analysis of SB 2375 prepared by the Senate Committee on Business and Professions, p.2). The Court in Landau, supra, relied on this goal, articulated in 1990 and arguably stated in 1993 to uphold the 1995 amendment to § 2337 at issue (App. at 18-21, 26). However, § 2337 as enacted as part of SB 2375 made *no* changes in appellate review to the right of physicians and surgeons to an appeal as of right of superior court decisions suspending or revoking their professional licenses. In 1993, State

Senator Robert Presley introduced SB 916 "to reform and improve the system for disciplinary enforcement over licensees of the medical board." SB 916 as originally introduced amended § 2337 to eliminate superior court review of medical board decisions and instead provided for "review of final decisions of an administrative law judge from the medical quality hearing panel shall be exclusively by appeal directly to the Third District Court of Appeal, which shall exercise its independent judgment in its review of the proceedings below" (SB 916, introduced by Senator Presley, March 3, 1993, Section 25, at p. 32). That language was changed prior to enactment to restore superior court review, to be replaced with the appellate courts by administrative mandamus pursuant to CCP § 1094.5 beginning January 1, 1995 until January 1, 1999.

However, before this provision for direct review in the Court of Appeal became effective, it was amended to extend the effective date to January 1, 1996. SB 609, which amended § 2337 into its present version, repealed the SB 916 version of § 2337 before it ever became effective. SB 916's repeal left intact appellate court review as a matter of right of superior court rulings in such cases until the present version of § 2337 took effect. The omission of a pre-existing definition of a term often indicates Congress' intent to reject that definition. See INS v. Cardoza-Fonseca, 480 U.S. 421, 432, 107 S.Ct. 1207, 1213, 94 L.Ed.2d 434 (1987).

The legislative history of the 1995 amendment to B&P § 2337 reveals that it was part of Senate Bill 609, introduced in early 1995. Senator Rosenthal originally introduced the bill to close some existing loopholes with respect to reporting requirements for physicians and surgeons of various criminal and other offenses (and to prevent fraudulent billing practices involving insurance companies, Medicare or MediCal)(April 3, 1995 Senate Business and Professions Committee Digest, pp. 1-2, Ex. "A", Request for Judicial Notice). B&P § 2337 was not

included in the original proposed bill (Id.). In fact, the portion of SB 609 amending § 2337 was not proposed until July 1995, at the request of the Judicial Council (Memorandum, Senate Policy Committee Legislative File, Assembly Files, Exhs. "B", "C", respectively, Request for Judicial Notice).[5] Nothing in the legislative history of SB 609 shows the purpose for amending § 2337 in this way.

Since Petitioner has a protected liberty interest in practicing his profession (Conn, supra, 526 U.S. at 291), heightened scrutiny under the Equal Protection Clause may be merited. However, a challenged classification will pass muster even under "rational basis" scrutiny only if it "rationally furthers some legitimate, articulated state purpose". San Antonio Independent School District v. Rodriguez, 411 U.S. 1, 17, 93 S.Ct. 1278, 1288, 36 L.Ed.2d 16 (1973). Without a legitimate, articulated state purpose in amending § 2337 in 1995, that amendment violates the Equal Protection Clause no matter what level of scrutiny this Court employs. California's Landau decision therefore conflicts with the principles this Court has set forth in Conn and Rodriguez, supra. This Court can resolve that conflict.

3. The District Court of Appeal's decision leaving intact the trial court's finding that the Medical Board had disciplinary jurisdiction over DR. DAY while he was on active duty in the Navy without disciplinary action imposed by the Navy conflicts with this Court's holding in Solorio.

5

Ironically, the legislative history shows that the California Department of Justice opposed this amendment to § 2337, arguing that doing away with the right of appeal from superior court judgments reviewing Medical Board actions (Exh. "D", Request for Judicial Notice).

Among the jurisdictional issues DR. DAY raised in his petition to the 1st District but never ruled on by that court was whether REAL PARTY exceeded its jurisdiction by instituting disciplinary proceedings against DR. DAY while he was on active duty in the Navy. Solorio v. United States, 483 U.S. 435, 107 S.Ct. 2924, 97 L.Ed.2d 364 (1987) holds that an active duty officer is under exclusive federal jurisdiction for disciplinary proceedings for any offenses committed while on active duty. Solorio, supra, 483 U.S. at 450-451. In doing so the court in Solorio established the determining factor in establishing military jurisdiction was the military status of the accused. Id at 438-450.[6] The Solorio court focused on the Constitution's grant of powers to Congress under Art. I, § 8, Cl. 14 of the Constitution to power "[t]o make Rules for the Government and Regulation of the land and naval Forces.' Solorio, supra, 483 U.S. at 438.

While Solorio involved the issue of whether active military status determined whether court martial proceedings could be brought even for non-service-related conduct, the basis for rejecting the test of whether conduct was service-related or not were military needs to regulate discipline and duty: "[T]he rights of men in the armed forces must perforce be conditioned to meet certain overriding demands of discipline and duty, and the civil courts are not the agencies which must determine the precise balance to be struck in this adjustment. The Framers expressly entrusted that task to Congress." Burns v. Wilson, 346 U.S. 137, 140, 73 S.Ct. 1045, 1048, 97 L.Ed. 1508 (1953) (plurality opinion) (footnote omitted). Solorio, supra, 483 U.S. at 440 (emphasis added).

In addition, this Court in Solorio reiterated that

> '"judicial deference...is at its apogee when

6

In so ruling, the Court overruled O'Callahan v. Parker, 395 U.S. 258, 89 S.Ct. 1683, 23 L.Ed.2d 291 (1969), which required a "service connection" for court-martial jurisdiction to apply.

> legislative action under the congressional authority to raise and support armies and make rules and regulations for their governance is challenged (citations omitted)....Since O'Callahan, we have adhered to this principle of deference in a variety of contexts where, as here, the constitutional rights of servicemen were implicated."'(citations omitted).

Solorio, supra, 483 U.S. at 447-448, 107 S.Ct. at 2931.

As a result, the argument that actions such as that brought by REAL PARTY against DR. DAY in this case may not be criminal in nature raises a distinction without a difference. These actions reflect REAL PARTY's disciplinary rationale and role analogous to that of the military's. "Medical boards in 39 states have participated in a sweeping evaluation of the way they license and discipline physicians..." Petitioner's Attachment 3, Medical Board of California, "39 State boards Conduct Self-Examinations: California Compares Well; Needs to Do Better", April 1995, p. i. (emphasis added). Congress derives its exclusive authority for court-martials and rules of conduct regulating military personnel from the same source ("[t]o make Rules for the Government and Regulation of the land and naval Forces", U.S. Const., Art. I, § 8, Cl. 14). See Solorio, supra, 483 U.S. at 438. Like the court-martial involved in Solorio, rules regulating military personnel conduct derive from Title 10, Part II of the United States Code, concerning Armed Forces Personnel. DR. DAY was only able to engage in his pain clinic practice with the Navy's permission. See 32 C.F.R. § 721.6(j),(l) (Appendix Exh."T", attached thereto). 32 C.F.R. § 721.6(j),(l) was authorized in part by 10 U.S.C. §§ 133 and 5031. Since the disciplinary roles are analogous, the Solorio active service test applies to bar any proceedings brought by REAL PARTY once the Navy recalled DR. DAY to active duty in December 1990, until DR. DAY was no longer on active duty.

As shown above, the Navy exercised its jurisdictional authority by bringing extensive disciplinary proceedings against DR. DAY, including his civilian practice (Exh. "21"). The Navy cleared him of all charges, after initially withdrawing its permission for DR. DAY to engage in off-duty medical practice (Appendix Exh. "A", Attachment 2 to points and authorities)including those relating to patient M.G. in this case (Exh."K") and the same kind of charges, i.e., thoracic catheter placement, as those relating to B.C. (Appendix Exh."I", 28:3-31:4). The trial court in this case considered B.C. as one of the keys to the case (Appendix Exh."E", 4:4-6, 5:1-6:25).

The BOARD may rely on B&P §2305 for jurisdiction. Yet jurisdiction under §2305 is derivative, depending on disciplinary action imposed by the federal government. Here, DR. DAY was cleared by the Navy using the preponderance of the evidence standard (Exhibits "J", "K", 25). The BOARD therefore could not and did not rely on §2305 in taking its action in this case. Solorio barred the BOARD's action in this case.

4. REAL PARTY could not discipline DR. DAY for matters not alleged in writing in the accusation against him.

Administrative Finding 64 (Appendix Exhs."A-l","I", 49:10-15) found that Petitioner allowed A.C.'s minor son "to be responsible for administering Narcan in a syringe to her if needed." Nowhere in the Second Supplemental Accusations regarding A.C. (Exh. 1, ¶¶ 21-52) did this allegation appear. The Medical Board therefore violated DR. DAY's due process rights.

License revocation proceedings are quasi-criminal in nature. In re Ruffalo, 390 U.S. 544, 551, S.Ct. 1222, 20 L.Ed.2d 117 (1968). As this Court stated in Ruffalo: "The charge must be known before the proceedings commence. They become a trap when, after they are underway, the charges are amended on the basis of testimony of the accused. He can then be given no

opportunity to expunge the earlier statements and start afresh." Ruffalo, supra, 390 U.S. at 551.

Ruffalo involved a disbarment proceeding. Ruffalo "had no notice that his employment of Orlando would be considered a disbarment offense until after both he and Orlando had testified at length on all the material facts pertaining to this phase of the case." Ruffalo, supra, 390 U.S. at 550-551. See also Cal. Gov't Code § 11503; Smith v. California State Board of Pharmacy, 37 Cal.App.4th 229, 241-243, 43 Cal.Rptr.2d 532 (Cal.App.4 Dist.1995).

Here, DR. DAY was prepared to defend as to the self-injection issue, not that he had the minor son administer the Narcan to A.C. (See Appendix Exh."E", 8:27-10:15). Upholding the charges in the face of that discrepancy was a violation of due process and necessitated a new trial. All the testimony showed was that A.C. was given Narcan in a syringe, which was given to A.C.'s attendant son (Vol. 4, 57:1-5). Nothing in the record stated that the son was responsible for administering Narcan to A.C. By letting this finding stand, the appellate court decision in this case conflicts with Ruffalo. This Court should clarify this point.

CONCLUSION

The petition for a writ of certiorari should be granted.

Dated: November 15, 2000

Respectfully submitted,
LAW OFFICES OF JOHN T. SCHREIBER

By _____
JOHN T. SCHREIBER,
Counsel of Record for Petitioner FRANKLIN J. DAY, M.D.

TABLE OF CONTENTS

Page

First Appellate District Opinion – Mar. 1999 ...App. 1

Order Dismissing Review (DAY) – June 2000...App. 10

Order Granting Petition for Review .....App. 11

Trial Court Order Denying Motion for New Trial – Aug. 1997 .....App. 13

Notice of Entry of Judgment.....App. 18

Statement of Decision, Judgment – June 1997...App. 20

Order Denying Petition for Administrative Mandamus – Feb. 1997 .....App. 102

Administrative Decision – July 1996.....App. 108

Proposed Decision .....App. 109

Constitutional Provisions, Statutes, Federal Regulations .....App. 202

LANDAU Order Dismissing.....App. 206

LANDAU Opinion .....App. 208

NOT TO BE PUBLISHED IN OFFICIAL REPORTS

IN THE COURT OF APPEAL OF THE
STATE OF CALIFORNIA
FIRST APPELLATE DISTRICT DIVISION THREE

FRANKLIN JEROME DAY, M.D., Petitioner, v. THE SUPERIOR COURT OF THE CITY AND COUNTY OF SAN FRANCISCO, Respondent; DIVISION OF MEDICAL QUALITY OF THE MEDICAL BOARD OF CALIFORNIA, Real Party in Interest.	A080131 (San Francisco County Super. Ct. No. 982562) (Filed Mar. 30, 1999)

This is a petition for writ of mandate to compel the reversal of a trial court decision denying a petition for administrative mandamus against respondent Division of Medical Quality of the Medical Board of California (the Board). Petitioner contends the trial court failed to review the entire administrative record before it, and as a result did not comply with its obligation to exercise its independent judgment upon the weight of the evidence. We deny the petition.

I. Factual and Procedural Background

Petitioner is a licensed California physician and surgeon specializing in treating chronic nonmalignant pain.

Beginning in February 1995, the Board brought a series of supplemental accusations against petitioner alleging repeated instances of gross negligence and incompetence in petitioner's treatment of a number of his patients. Following a 22-day administrative disciplinary proceeding, the administrative law judge (ALJ) issued lengthy findings of fact and determined there was cause to discipline petitioner. The ALJ recommended that petitioner's license be revoked, with revocation stayed and petitioner placed on probation for a period of five years with conditions including further education, the successful completion of an oral clinical examination, and monitoring of his probation by another physician in petitioner's field of practice. The ALJ's proposed decision and recommendations were adopted in their entirety by the Board.

Petitioner filed a petition for administrative mandamus in superior court seeking to overturn the Board's license discipline. Following proceedings on the petition for administrative mandamus, the trial court issued a detailed statement of decision reviewing the evidence in the administrative record on the basis of the "independent judgment" standard, and denying the writ. In his motion for a new trial, petitioner argued the court could not have exercised its independent judgment on the administrative record, based on the fact that during a visit to the courthouse he had observed 17 of the 22 volumes of administrative record transcripts unopened, and had taken photographs to prove it.

At the hearing on the motion for a new trial, the trial judge acknowledged he had not "read every word of all the transcripts," but affirmed he had "read everything" material to the issues in the case to which his attention

had been directed by petitioner's briefs.[1] The trial court denied the motion for a new trial. The petition to this court followed.

---

[1] The following colloquy took place between the trial court and counsel for petitioner at the August 12, 1997, hearing on petitioner's motion for a new trial:

"THE COURT: As I understand your papers, Mr. Schreiber [petitioner's counsel], you want a new trial because you found some transcripts, some of the record unopened in my courtroom in Department 8?

"MR. SCHREIBER: That's correct, Your Honor. That's one of the grounds, 17 of the 22 based on the photographs.

"THE COURT: That's probably right. I'm not going to argue about that.

"I read the briefs. I look at the cites in the brief. I try to find the language that makes the difference in the brief. I don't read every word of all the transcripts. That's fine. I read everything I needed to read, and I'm pretty comfortable I did the right thing.

"If you have a case that says that I have to read every word of every transcript of a 22-day hearing, the Court of Appeal will have to discuss that with you.

"MR. SCHREIBER: Well, it may well, Your Honor. I understand it's a large record and heavy duty.

"THE COURT: And I did what I thought was professionally the right thing to do. We did read I don't remember how much of the record, but we read a lot of it, and you found five open.

"MR. SCHREIBER: Five volumes out of twenty-two, Your Honor, and the problem is that because a fundamental vested right is at stake here –

"THE COURT: What did I miss? What did I miss? What's in the record that I didn't get?

"MR. SCHREIBER: All right. I can go through that fairly easily. It's in my papers.

II. Discussion

The central claim of this petition is that the trial court could not have exercised its obligation under the

---

"THE COURT: I have read your papers, but it's the same arguments that were made before, which is, this is a very misunderstood area of medicine. It's pain management. And what I got in your papers was the same as what I had before.

"MR. SCHREIBER: Well, let me see if I can point you to some specifics.

" .....

"THE COURT: . . . You must have cited in your papers the right testimony that I would need in order to –

"MR. SCHREIBER: I certainly did, Your Honor, and I'm in the process of going to those specific points.

"THE COURT: Why wasn't it included in your points and authorities? What I do is, I look at the briefs and see what you cite me to, because those are the most important things, and I do what I think needs to be done.

"But you can tell the Court of Appeal, yeah, I didn't read all 22 volumes, that's true. But I read everything I thought I needed to read, and I had access to it all.

" .....

"MR. SCHREIBER: Your ruling seems to be heading in the direction that you do not need to review each and every exhibit, each and every page of the record. How do you square that, then, with footnote 10 of the *Bixby* case [*Bixby* v. *Pierno* (1971) 4 Cal.3d 130]?

"THE COURT: Talk to the Court of Appeal, and see if I have to do that. I am saying on the record I didn't review everything. I don't know whether you have the right numbers of what I reviewed. I don't remember now.

"But I always and I do remember here reading transcripts. I do remember looking at exhibits. I did all that. I did not read everything.

independent judgment standard to review the entire administrative record, based on the trial judge's admission he had not read every word of the transcript, and the fact 17 of the 22 transcripts of the administrative record were unopened. In response to this court's request for further briefing, the Board argues there is no appellate or statutory authority requiring a trial court, in the context of an administrative mandamus proceeding, to review every word of every transcript and exhibit in order to exercise its independent judgment. Instead, contends the Board, the burden rests on the party challenging the administrative decision to bring to the court's attention the relevant portions of the administrative record purportedly showing the administrative decision is contrary to the weight of the evidence.

In support of its position, the Board cites the leading case of *Drummey v. State Bd. of Funeral Directors* (1939) 13 Cal.2d 75 (*Drummey*), the seminal decision holding that administrative mandamus is the appropriate method for challenging a license discipline by a state agency, and establishing the "independent judgment" standard of mandamus review. In *Drummey*, our Supreme Court stated: "The [administrative] findings of the board come before the court with a strong presumption of their correctness, and the burden rests on the complaining party

---

"It's possible that you found the right thing, no doubt about it. Go to the Court of Appeal. If the Court of Appeal orders me to read everything, they'll send it back here, and I'll do it.

"But I don't think that's the responsibility I have here. I could be wrong."

to convince the court that the board's decision is contrary to the weight of the evidence." (*Id.* at p. 85.)

In response, petitioner cites the Supreme Court's statement in *Bixby v. Pierno, supra,* 4 Cal.3d 130, 143, as follows: "By carefully scrutinizing administrative decisions which substantially affect vested, fundamental rights, the courts of California have undertaken to protect such rights, and particularly the right to practice one's trade or profession, from untoward intrusions by the massive apparatus of government. If the decision of an administrative agency will substantially affect such a right, the trial court not only examines the administrative record for errors of law but also exercises its independent judgment upon the evidence disclosed in a limited trial de novo." (Fn. omitted.) In a footnote relied upon by petitioner, the *Bixby* court added: "The trial court must exercise its independent judgment upon the weight of the evidence produced or which could not, in the exercise of reasonable diligence, have been produced before the administrative agency and any evidence which might have been improperly excluded by the administrative agency. [Citations.] After the trial court has exercised its independent judgment upon the weight of the evidence, an appellate court need only review the record to determine whether the trial court's findings are supported by substantial evidence. [Citations.] [¶]The substantial evidence test requires the trial court to review the entire record. [Citations.] Once we have imposed the obligation upon the trial court to review the entire record, the additional duty of deciding the matter on the basis of an independent judgment does not entail a significantly

more serious burden. [Citation.]" (*Id.* at pp. 143-144, fn. 10.)

At the hearing on petitioner's motion for a new trial, his attorney argued to the trial court that *Bixby* required the court "to review each and every exhibit, each and every page of the record." We do not read *Bixby* to place such an onerous duty on a trial court considering a petition for writ of administrative mandamus. It is true, as stated in *Bixby v. Pierno* (1971) 4 Cal.3d 130, that the trial court has the obligation "to review the entire record." (*Id.* at pp. 143-144, fn. 10.) Nevertheless, because the burden of persuasion is on the petitioner in an administrative mandamus proceeding, it is the *petitioner's* obligation "to convince the court" that the administrative decision "is contrary to the weight of the evidence." (*Drummey, supra,* 13 Cal.2d at p. 85.)

The key to our decision is the distinction between "reading" and "reviewing." In order to "review the entire record" it is not strictly necessary to read every word, as long as the petitioner has directed the attention of the court to those material portions of the record he or she contends undermine the administrative decision. (Cf. *Williams v. Williams* (1971) 14 Cal.App.3d 560, 565 ["[i]t is incumbent upon the parties to an appeal to cite the particular portion of the record supporting each assertion made. It should be apparent that a reviewing court has no duty to search through the record to find evidence in support of a party's position"].) Because "the burden rests on the complaining party to convince the court that the [administrative] decision is contrary to the weight of the evidence" (*Drummey, supra,* 13 Cal.2d at p. 85), the trial court is required to read only those parts of the

administrative record to which its attention has been directed by the party with the burden of persuasion. Thus, a court may review a record without necessarily reading *every word* in it.

In this case, as he himself points out, petitioner actually reproduced and attached as an appendix to his original petition to the trial court the text of most of the material from the administrative record on which he relied in his writ petition. Thus, the trial court did not have to open all the actual reporters' transcripts of the administrative record in order to peruse the citations on which petitioner was relying, since petitioner had already provided the relevant texts as part of his own petition and the trial court could read them there. Moreover, petitioner completely ignores the fact the trial court also had available to it literally thousands of pages of attached exhibits and documentary evidence contained in 22 additional volumes of administrative record accompanying his writ petition.[2] Petitioner has never alleged that the trial court failed to review *this* evidence, and there is nothing to suggest that it did not do so.

---

[2] These 22 volumes of "Attached Exhibits" to the administrative record must be distinguished from the 22 volumes of reporter's transcript also in the administrative record. Unlike the 22 volumes of administrative hearing reporter's transcript, these additional (and far more massive) 22 volumes of documentary evidence were apparently never individually wrapped in envelopes. It was petitioner's discovery of 17 unwrapped volumes of reporter's transcript that triggered its argument the trial court had failed to review the entire record. There is no contention the trial court failed to review the documentary and evidentiary portions of the administrative record.

In sum, the petitioner bore the burden of persuasion; it was his job to *convince* the trial court that the evidence he cited was material to his arguments. (*Drummey, supra*, 13 Cal.2d at p. 85.) If the petitioner's arguments were themselves substantively unpersuasive on their face, no amount of citation to the record could make a difference. On the basis of our own inspection of the arguments and citations made by petitioner to the trial court in his various briefs, the massive documentary evidence in the record, the testimonial material contained in the transcripts which the trial court undoubtedly did review, and the evidentiary appendices attached to the original petition, we conclude the trial court did conduct an independent review of the record, and its determinations were supported by substantial evidence.

III. Disposition

The petition for writ of mandate is denied.

McGuiness, P.J.

We concur:

Parrilli, J.

Walker, J.

Mar. 31, 1999

First Appellate District, Division Three No. A080131
S078077

IN THE SUPREME COURT OF CALIFORNIA
EN BANC

FRANKLIN JEROME DAY, M.D., Petitioner

v.

SAN FRANCISCO COUNTY SUPERIOR COURT,
Respondent
DIVISION OF MEDICAL QUALITY OF THE
MEDICAL BOARD OF CALIFORNIA,
Real Party in Interest

(Filed Jun 14, 2000)

Pursuant to rule 29.4(c), California Rules of Court, the above-entitled review is DISMISSED and cause is remanded to the Court of Appeal, First Appellate District, Division Three.

George
Chief Justice

Baxter
Associate Justice

Werdegar
Associate Justice

Chin
Associate Justice

Associate Justice

Associate Justice

Associate Justice

First Appellate District, Division Three No. A080131
S078077

IN THE SUPREME COURT OF CALIFORNIA

FRANKLIN JEROME DAY, M.D., Petitioner

v.

SAN FRANCISCO COUNTY SUPERIOR COURT,
Respondent
DIVISION OF MEDICAL QUALITY OF THE
MEDICAL BOARD OF CALIFORNIA,
Real Party in Interest

(Filed Apr. 28, 1999)

Petition for review GRANTED.

Further action in this matter is deferred pending consideration and disposition of a related issue in *Leone v. Medical Board*, S065485 (see Cal. Rules of Court, rule 29.2(c)), or pending further order of the court. Submission of additional briefing, pursuant to California Rules of Court, rule 29.3, is deferred pending further order of the court.

Application for stay denied.

Mosk, J., is of the opinion the application for stay should be granted.

George
Chief Justice

Mosk
Associate Justice

Kennard
Associate Justice

Baxter
Associate Justice

Werdegar
Associate Justice

Chin
Associate Justice

Associate Justice

DANIEL E. LUNGREN, Attorney General
of the State of California
ALFREDO TERRAZAS, State Bar No. 78403
Deputy Attorney General
2101 Webster Street, 12th Floor
Oakland, California 94612-3049
Telephone: (510) 286-3795
Facsimile: (510) 286-4020

Attorneys for Respondent
Medical Board of California

[SEAL]

**IN THE SUPERIOR COURT
OF THE STATE OF CALIFORNIA FOR THE
CITY AND COUNTY OF SAN FRANCISCO**

FRANKLIN JEROME DAY, M.D. Petitioner, vs. **DIVISION OF MEDICAL QUALITY OF THE MEDICAL BOARD OF CALIFORNIA** Respondent.	**NO. 982562** **[PROPOSED JUDGEMENT [sic] AND ORDER DENYING MOTION FOR NEW TRIAL AND DENYING ORDER SETTING ASIDE JUDGMENT** **DATE: To Be Set (See TIME: Code Civ. Proc. DEPT: § 661, Judge Cahill**

This matter was scheduled and heard before this Court on August 12, 1997. Alfredo Terrazas, Deputy Attorney General, appeared as counsel for respondent the Division of Medical Quality of the Medical Board of California. The appearance on behalf of petitioner was

made by John T. Schreiber, Esq., and oral argument was held.

The record of the writ of mandate proceedings having been previously received and examined by the Court, and additional oral and written arguments and legal briefings having been submitted by the parties in their respective written moving and responsive pleadings;

THE COURT FINDS, that:

(1) Petitioner's stated grounds for a Motion for a New Trial And For An Order Setting Aside Judgment do not meet the statutory requirements of Code of Civil Procedure section 657;

(2) There was no irregularity in the proceedings in the consideration of petitioner's Petition for Writ of Mandate before this Court;

(3) The Court exercised its independent judgment in reviewing the administrative record, ~~including the administrative transcripts~~ [as discussed on the record on Aug. 12, 1997] [WC] in determining whether the administrative findings were supported by the weight of the evidence;

(4) There was no accident or surprise at either the *limited trial de novo* on the Petition for Writ of Mandate before this Court or at the administrative hearing below;

(5) ~~The *"Declaration of Franklin Jerome Day M.D. in Support of Motion for New Trial* was not filed and served in a timely manner (C.C.P. 659);~~ [WC]

(6) Respondent has jurisdiction to discipline one of its licentiates and it is not barred from doing so by the holding in *Solorio v. United Stated* [sic] (1987) 483 U.S. 435;

(7) Petitioner has failed to demonstrate that the outcome of either the Petition for Writ of Mandate, which was denied by this Court, or the administrative disciplinary proceeding, disciplining his medical license, were, in fact, influenced by the failure to consider the proffered, newly discovered evidence which petitioner describes as the "Legislative History" of the so-called "Intractable Pain" statute, Business and Professions Code § 2241.5;

(8) Petitioner herein has not established that newly discovered evidence could not, in the exercise of reasonable diligence, have been discovered and produced either before this Court during the *limited trial de novo* on the Petition for Writ of Mandate or at the administrative hearing below; and

(9) The evidence before this Court during the *limited trial de novo* on the Petition for Writ of Mandate and at the administrative hearing below was sufficient, in both instances, to justify the decision of the Medical Board disciplining petitioner's certificate to practice medicine.

WHEREFORE, IT IS HEREBY ORDERED, ADJUDGED AND DECREED THAT:

1. The Motion for New Trial and for an Order Setting Aside Judgment is DENIED; and

2. ~~The following Petitioner's Exhibits and Declarations, having been properly objected to, are specifically not admitted as evidence into the administrative record~~

~~and further not admitted as evidence in the Motion For a New Trial:~~

A. ~~Declaration of Franklin Jerome Day, M.D., M.D., in Support of Motion For New Trial, with exhibits.~~ [WC]

3. Petitioner's Request for Judicial Notice to augment the administrative record with post-administrative hearing Exhibits consisting of three documents; the Declaration of Jan S. Raymond, a Director of the Legislative Intent Service (Exhibit "A"); a copy of the Legislative Digest to Business and Professions Code § 2241.5 (Exhibit "B"); and a copy of the Senate Committee on Business and Professions Digest, May 7, 1990 on SB 1802 (Exhibit "C") is [granted].

~~No satisfactory showing has been made before this Court that said Declarations and exhibits could not, in the exercise of due diligence, have been produced before either this Court as part of the Petition for Writ of Mandate action or before the Administrative Law Judge for an evidentiary ruling. To allow these into the record, without foundation as to their accurate reflection of the entire legislative history of the so-called~~ [WC] ~~"Intractable Pain" statute, would also be more prejudicial than probative. Thus, they are also inadmissible under Evidence Code section 352.~~ [WC]

4. Petitioner take nothing by its action; and

5. Respondent be awarded its costs of this proceeding.

DATED: August 12, 1997.

/s/ William Cahill
THE HONORABLE
WILLIAM CAHILL
Judge of the Superior Court

DANIEL E. LUNGREN, Attorney General
of the State of California
ALFREDO TERRAZAS, State Bar No 78403
Deputy Attorney General
2101 Webster Street, 12th Floor
Oakland, California 94612-3049
Telephone: (510) 286-3795
Fax No.: (510) 286-4020

Attorneys for Respondent

IN THE SUPERIOR COURT OF THE STATE OF CALIFORNIA FOR THE CITY AND COUNTY OF SAN FRANCISCO

FRANKLIN JEROME DAY, M.D. Petitioner, vs. **JONATHAN LEW, ADMINISTRATIVE LAW JUDGE, OFFICE OF ADMINISTRATIVE HEARINGS, DIVISION OF MEDICAL QUALITY OF THE MEDICAL BOARD OF CALIFORNIA** Respondents.	**NO. 982562** **NOTICE OF ENTRY OF JUDGMENT** **[ccp § 664.5 (a)]**

TO: **FRANKLIN JEROME DAY, M.D. and JOHN T. SCHREIBER ESQ.**, his Attorney of Record.

NOTICE IS HEREBY GIVEN that on June 16, 1997, judgment was entered in the above-entitled action, by way of a Statement of Decision, in favor of respondent Jonathan Lew, Administrative Law Judge, Office of

Administrative Hearings, Division of Medical Quality of the Medical Board of California, and against petitioner, Franklin Jerome Day, M.D.

DATED: June 19, 1997

DANIEL E. LUNGREN,
Attorney General of the
State of California

/s/ Alfredo Terrazas
ALFREDO TERRAZAS
Deputy Attorney General
Attorneys for Respondent
Division of Medical Quality
of the Medical Board
of California

DANIEL E. LUNGREN, Attorney General
of the State of California
ALFREDO TERRAZAS, State Bar No. 78403
Deputy Attorney General
2101 Webster Street, 12th Floor
Oakland, California 94612-3049
Telephone: (510) 286-3795

Attorneys for Real Party in Interest
Medical Board of California

IN THE SUPERIOR COURT OF THE
STATE OF CALIFORNIA
IN AND FOR THE COUNTY OF CONTRA COSTA

FRANKLIN JEROME DAY, M.D. Petitioner, vs. JONATHAN LEW, ADMINISTRATIVE LAW JUDGE, OFFICE OF ADMINISTRATIVE HEARINGS, Respondents.	**No. 982562** **STATEMENT OF DECISION (CCP § 632; Cal. Rule of Court § 232(c))** (Filed June 16, 1997)

This matter was scheduled and heard before this Court on January 31, 1997. Alfredo Terrazas, Deputy Attorney General, appeared as counsel for Respondent the Division of Medical Quality of the Medical Board of California. The appearance on behalf of Petitioner was made by Franklin Jerome Day, M.D., *in propia persona*, and oral argument was held.

Having reviewed the petition and accompanying documents, the opposition papers, as well as having heard oral argument and reviewed and received into evidence the record of the administrative proceedings below, this Court, having duly considered the matter and having exercised its independent judgment pursuant to Code of Civil Procedure section 1094.5, issues the following Statement of Decision in conformity with its *Order Denying Petitioner's Writ of Mandate:*

A. A principal controverted issue at trail [sic] was whether the findings of the Board were supported by the evidence. The Court finds that the Board's FINDINGS OF FACT, and DETERMINATION OF ISSUES at pages 8 through 55, inclusive, of its DECISION, were supported by the weight of the evidence. The factual and legal basis for this determination is as follows:

I. Patient M.O.

First and Second Causes for Disciplinary Action

Treatment History – Patient M.O.

a. Patient M.O. was first seen by Petitioner on January 23, 1987. She was 35 years old at the time, and presented with chief complaints of neck, back, and left arm pain. Her symptoms related back to an industrial accident occurring on April 9, 1985. She had been seen by several other doctors before being referred at her request by Marvin Zwerin, M.D. to Petitioner for management of her pain.

b. M.O. was a former body builder and aerobics instructor. While working in April 1985 as a freight cashier for Hanjin Container, she was startled by noise from a

robbery in progress, and twisted her neck. Within a day she developed severe pain in her neck and pain in her left upper arm, left shoulder and the upper left hand quadrant of her back. Following initial treatment by a chiropractor, she underwent a neurological evaluation. Magnetic Resonance Imaging (MRI) scans indicated a herniated disc at the C5-6 level, and eventually she underwent a cervical discectomy at this level with an anterior fusion in September 1985. Surgery was followed by six weeks bed rest. The patient testified at the hearing that there was no significant improvement in her pain.

c. Prior to seeing Petitioner, M.O. had received trials of treatment of physical therapy, acupuncture, TENS (Transcutaneous Electrical Nerve Stipulation), traction, ice, spray and stretch, massage with ultrasound, and trigger point injections with local anesthetic and cortisone; all with little effect. Medications that had been tried included Vicodin, Talecin, Xanax, Parafon Forte, Naprosyn and Elavil.

d. On her first visit with Petitioner, M.O. completed a fairly comprehensive personal medical history. It included detail on medications, past treatments/therapies, location and degree of pain and other relevant personal/medical information. There is also a two page record of a physical examination performed that day, again detailing her complaints of pain, symptoms and pertinent treatment history. (*See*, Exhibit JJ) A plan of treatment is not part of the initial history and physical examination. However, progress reports for that visit

indicate that Petitioner felt that she had a sympathetic dystrophy in addition to her chronic cervical strain. After performing a differential thoracic epidural block (incremental injections of .5% lidocaine) to confirm the sympathetic component of her pain, his progress notes record a plan to have her return in three days for repeat sympathetic blocks, as necessary. He also gave her an epidural injection of 80 mg Depo-Medrol, and planned to follow-up in one week for repeat epidural steroids.

e. By letter dated February 11, 1987 to referring physician Dr. Zwerin, Petitioner provided his initial diagnostic impressions and treatment plans for M.O. He opined that M.O. was suffering from a combination of chronic cervical nerve irritation and a reflex sympathetic dystrophy, confirmed by the differential epidural block results. The cervical epidural steroid injections were for the suspected nerve root inflammation and irritation. Petitioner noted that with an aggressive series of epidural steroid injections, she started getting substantial periods of improvement in her pain. He also performed trigger point injections in the trapezius with local anesthetic. He noted on February 11:

> "[M.O's] problems have been longstanding and complex and I'm not yet sure how long she will require treatment here. She does seem to be responding to our therapy, although not as rapidly as I would have anticipated. Hopefully, physical therapy combined with my treatments will allow her a chance for full rehabilitation. I will continue to aggressively pursue therapies." (Exhibit 8, 2/11/87 Letter to Dr. Zwerin)

f. Petitioner did engage in aggressive treatment of M.O. between January 23 and October 27, 1987, during which time there were approximately 56 office visits. Within a week of starting treatment with Petitioner, M.O. was prescribed the more potent drug Methadone, and taken off Vicodin. Over the treatment period petitioner performed 14 epidural local anesthetic or epidural differential local anesthetic blocks, 24 epidural steroid injections, 9 stellate ganglion blocks with local anesthetic, 19 sets of trigger point injections and 1 Bier block.

g. On June 22, 1987, Petitioner noted that he would begin instructing M.O. on self-injection of Duramorph (morphine) epidurally and would give her a ten day supply of same to see if he could achieve "long lasting relief." Thereafter, M.O. continued self-injection of morphine daily until her September hospitalization for the infection at the site of the epidural catheter. In answer to her queries, Petitioner told M.O. that she would not become addicted to the morphine because it was being injected directly into the epidural wall of her spine. M.O. would receive temporary relief from her pain until the medications would wear off. Petitioner told her that if she could continue with the treatment for six months to a year, that her pain condition would be better.

h. Petitioner also referred her for a functional capacity assessment performed at Wilson's Physical Therapy. In view of her emotional lability and slow response to therapy, Petitioner referred her to a psychiatrist to help her deal with the emotional problems associated with her chronic pain. A psychological consultation was performed by Douglas Korpi, Ph.D. on July 30, 1987. Dr. Korpi opined that she had an adjustment disorder with

mixed emotional features, and that psychological factors affected her physical condition. Commenting upon the issue of placing a permanent catheter in order for her to self-administer morphine, he notes:

> "She does not appear to be gaining any sort of secondary gain from her current injury. She does not appear an inherently addictive personality. She is not someone who would be necessarily psychologically ill-advised to take the proposed morphine treatment, however, she is quite frantic right now. Her reality testing and judgment are impaired, and she is having difficulty grappling with the fact of her physiological limitation . . . . [M.O.] should be given the morphine treatment only if it is judged to be a sound medical practice. For her part, she is willing to try just about anything right now." (Exhibit 8)

Petitioner attempted to obtain permission from her medical insurance carrier to place a permanent epidural catheter for her, but was unsuccessful in doing so.

i. Petitioner's approach to treating M.O. was to pursue combination therapies at a given time. During a single office visit, M.O. might receive epidural blocks containing both local anesthetic and steroids, with a stellate ganglion block and/or trapezius trigger point injection. A temporary epidural catheter was in place almost continuously. It was replaced whenever it was pulled out too far or otherwise associated with inflammation or nonfunction. As noted by the ALJ, its replacement was not dictated by any apparent schedule.

j. From September 11 through 19, 1987, M.O. was hospitalized at Los Medanos Community Hospital for an

infection at the site of the epidural catheter. Her final diagnosis upon discharge was cellulitis C7-T1 interspace, organ streptococcus. It was a direct result of the epidural catheter placed at that site. Patient M.O. testified that, at Petitioner's instruction, M.O. had removed the catheter the day before proceeding to the hospital. During this hospitalization, M.O. was advised by William Johnson, M.D. that she was "addicted" to narcotics and that she should not return to the course of treatment that Petitioner had been administering. M.O. began experiencing withdrawal symptoms at that same time, and felt that nursing staff were rude and treated her differently because she was a "junkie."

k. After her hospitalization, she weaned herself off the morphine and methadone. She refused to allow Petitioner to place another catheter through which she could inject any more narcotics. She became very sick, with vomiting and sweating. Upon seeing her personal physician John Chokatos, M.D. and endocrinologist Todd Lorenz, M.D., she was admitted to Providence Hospital on November 13, 1987 with an initial impression of adrenal insufficiency manifested by tremulousness, sweats, weakness and hyponatremia. She was discharged on November 18, 1987 with no clear endocrine problem found except for a secretory defect. A CT (Computerized Tomography) scan showed normal adrenal glands. She was discharged on a regimen of hydrocortisone and maintained on same for approximately six months thereafter.

l. Petitioner was aware of the potential side effects of long term steroid injections. His April 6, 1987 progress report notes:

> "I am starting to note some fullness in [M.O.'s] face. It is apparent that we are starting to see some side effects from the steroid injections. However, I will continue to pursue these injections and try to stretch out the time in between injections in an attempt to minimize any side effects from the steroids."

Petitioner opined on January 25, 1988 that M.O. "had developed an Addisonian type picture probably from the aggressive use of the epidural steroid injections and presently is being treated by an endocrinologist." During the administrative hearing, Petitioner disputed such diagnosis or linkage to his treatment. Hospital tests indicated that she had no adrenal shutdown, and that her adrenals were functioning normally.

Accusation Allegations – Patient M.O.

At *Accusation Paragraph 28A* – Respondent Medical Board alleged that Petitioner in a grossly negligent and/or negligent and/or incompetent manner, employed the use of multiple epidural steroid injections in an excessive manner which directly led to the suppression of the hypothalamic pituitary adrenal axis in Patient M.O., hence the development of Addison's disease.

As noted by the ALJ, epidural steroid injections are quite useful for treating a variety of chronic pain syndromes. Michael C. Rowbotham, M.D., one of the medical experts called by Respondent Medical Board, opines that the limitation usually observed for this procedure is for the injections to be performed at approximately two week intervals for a total of 3 injections every six months in

order to prevent suppression of the hypothalamic pituitary adrenal axis. The record shows that Petitioner performed 24 steroid injections over eight months. He suggests that risks for excessive steroid use include adrenal insufficiency if the nerve blocks were discontinued, injury to the ligaments in the spine, osteoporosis and chronic inflammation and scarring including arachnoiditis.

As further noted by the ALJ in this case, several factors mitigate in Petitioner's favor. First, he was aware of expected side effects of epidural steroids and monitored M.O. carefully, as his April 6, 1987 progress report indicates. Second, he was careful to inject only the physiologic dose needed to minimize toxicity. For example, on April 24, 1987, he reports that she was receiving an average of 4 mg of Prednisone a day (40 mg. Depo-Medrol over ten days) and that this amount "is physiologic and should allow us to continue the steroid injections." Petitioner reasonably argued, and the ALJ accepted, that the danger with steroid injections is the total *dosage* over time, and not the total number of injections. He also believes that steroids would be most effective if administered locally, and not orally. To the extent that risks were associated with long term injection of steroids, Petitioner testified that he recalls discussing same with M.O. Third, it was not established that M.O. developed Addison's disease (adrenal insufficiency) or any other abnormality of her hypothalamic pituitary adrenal axis. Interestingly, M.O. was discharged in November 1987 with a finding of normal adrenal gland functioning, and placed on a six month regimen on the steroid hydrocortisone. Such a finding and her steroid regimen run counter to criticisms

that Petitioner provided her epidural steroid injections in an excessive manner prior to her hospitalization.

For these reasons, the ALJ found that it was not established that the multiple epidural steroid injections employed by Petitioner were either excessive or that they led to her development of Addison's disease or related adrenal crisis. This Court is likewise convinced that Petitioner's conduct in performing epidural steroid injections did not lead to the development of Addison's disease or related adrenal crisis.

At *Accusation Paragraph 28B* – Respondent Medical Board alleged that Petitioner failed to design an adequate long-term treatment plan for patient M.O. deciding instead on performing invasive procedures, from one office visit to the next, dictated by short term responses only. Dr. Rowbotham, another of Respondent's medical experts, opined that there is no indication anywhere in the notes that an adequate long-term treatment plan was in place and that upper limits existed on the intensity with which Petitioner planned to use the highly invasive means of pain control. The ALJ found that while a treatment plan was not developed as part of his initial history and physical, Petitioner was still in the diagnostic stage and planned on administering a differential thoracic epidural block to confirm the sympathetic component of her pain. Within weeks, Petitioner had prepared a letter to the referring physician reporting on his findings and recommending a treatment plan for M.O. (*See*, PROPOSED DECISION, Finding 13d and 13e).

Thereafter he maintained fairly detailed progress reports which commented on changes in treatment dictated by her short term responses to therapy. Throughout, Petitioner's rationale for given treatments are explained. In the content of her demonstrating progressive long term benefits, this approach was consistent with his earlier treatment plan. As found by the ALJ and also by this Court, it was not established that Petitioner failed to design an adequate long term treatment plan for M.O.

At *Accusation Paragaphs 28C/28D* – Respondent Medical Board alleged that Petitioner in a grossly negligent and/or negligent and/or incompetent manner, used morphine on an ongoing basis to control M.O.'s pain, and that he improperly employed the prolonged use of temporary catheters in her care and treatment.

The medical opinion of Board expert Marvin H. Lipton, M.D., though reflective of the more conservative and objective approach taken by many orthopedists, was largely disregarded by the ALJ in his decision in that Dr. Lipton would seem to limit the use of epidural injections of morphine to patients with "metastatic disease, intractable pain, and a limited life expectancy." Dr. Rowbotham's concerns are similar but more qualified. He notes:

> "The risks of the epidural route do not justify the anticipated benefit. In addition, there are difficulties with prolonged injection into the epidural space on a daily basis with the ability of the drug to penetrate to its intended site of action other than by systemic absorption and redistribution to the area affected. The use of epidural opioids does not represent negligence

> but the prolonged use of temporary catheters would be considered negligent by most specialists in this area."

Dr. Rowbotham believes that a mitigating factor is that the catheters were continuing to be used on a temporary basis only because Petitioner had not yet received approval for surgical placement of a sterile implanted epidural catheter system. As was well documented in his Proposed Decision, ALJ Lew noted that the use of morphine on a long term basis via temporary epidural catheter for chronic non-malignant pain is clearly controversial. ALJ Lew then indicated that the analysis should therefore be individualized, and inquiry made on the more narrow issue of whether a physician in good faith believes that a patient suffering from injury or ailment requires such treatment, and then only in such quantity and for such length of time as are reasonably necessary. Such an analysis is sound and supported by the weight of the evidence.

Patient M.O. was a complicated case. She had already received a number of other pain therapies prior to seeing Petitioner (*See*, PROPOSED DECISION, Finding 13c), and Petitioner continued to take a combination therapy approach in developing a treatment plan for her. It included physical therapy and psychiatric evaluation, even on the specific issue of whether proposed morphine treatment would be appropriate (Finding 13i). It is clear that he followed her very carefully and that his choices for intervention were neither haphazard nor arbitrary. It appears from Petitioner's medical records and from his testimony that he believed in good faith that M.O.'s condition required such morphine injections, and that he

administered it in such amounts and for such time as he believed reasonably necessary at the time. In fact, Dr. Rowbotham did not believe that the total number of epidural opioid injections reflected gross negligence. It was his concern about self-injection that raised it to the level of gross negligence.

Petitioner's use of temporary catheters looked ahead to insurance approval of a permanent epidural catheter, and under these circumstances ALJ Lew found that Petitioner cannot be faulted for using them as an interim measure. For all the above reasons, this Court concurs with the ALJ that it was not established that Petitioner's use of morphine on a long term basis for M.O.'s chronic pain, or his use of temporary catheters in her care and treatment, departed substantially from the standard of care.

At *Accusation Paragraph 28e* – Respondent Medical Board alleged that Petitioner improperly encouraged and allowed M.O. to self-inject opiate medications through an epidural catheter.

ALJ Lew found that notwithstanding Petitioner's care in training M.O. to self-inject opioid medications through her epidural catheter, allowing her to do so departed substantially from the standard of care. The ALJ noted that, at a minimum, a visiting nurse or home therapies group should have been administering the injections. The testimony at the administrative hearing clearly pointed out that there is a high potential for infection or dosing error. A medically trained person should perform the procedure and observe the site for evidence of problems including infection. A lay person is not so qualified.

In fact, one of Petitioner's entries indicates that M.O. and her husband would manipulate the catheter by slowly pulling it out in order to get an adequate injection. This is clearly not a simple and safe procedure for patients to perform on their own.

Board expert Michael Levin, M.D. opined that "allowing the patient to self-inject entails a high risk of infection in the epidural or intrathecal space, leading to permanent neurological damage or even death." While this risk is well recognized when allowing terminal cancer patients to self-inject, it would not be acceptable for non-cancer patients. ALJ Lew called this a straight benefit/risk approach. For chronic non-malignant pain, the risks clearly outweigh the benefits of self-injection. The weight of the evidence supports these findings by ALJ Lew.

Petitioner below cited a journal article in support of allowing patient self-injection of morphine for non-cancer pain, but as pointed out by the ALJ in his written decision, even that article points to the dangers and limitations of this practice and it does not purport to set the standard of care.[1] Similarly, Petitioner's parallels to

---

[1] Plummer, John L. **Long term spinal administration of morphine in cancer and non-cancer patients – a retrospective study**; Pain 1991; 44:215-20. This study followed 313 patients who had been treated with spinal morphine via an implanted Port-A-Cath. Twelve were non-cancer patients. The author notes:

> "Our reporting of [non-cancer] patients should not be construed as a recommendation for indiscriminate or widespread use of spinal opioids in this patient group. Patients reported here represent a small and

diabetic self-injections were rejected by the ALJ as not at all analogous. First, such injections are intramuscular, and not into the epidural space. Second, the consequences of not having such done by the patient when needed can lead to diabetic shock, coma or worse. The balance clearly weighs in favor of diabetic patient self-injection in such cases. The same is not true for chronic non-cancer pain.

This Court has determined that the ALJ's finding that it was established that Petitioner in a grossly negligent and incompetent manner encouraged and allowed M.O. to self-inject opiate medications through an epidural catheter is supported by the weight of the evidence. M.O. began self-injecting morphine in June 1987, and continued until her hospitalization in September 1987 for an infection at the catheter site (*See*, PROPOSED DECISION, Finding 13j), the very risk associated with self-injection.

At *Accusation Paragraph 28F* – Respondent Medical Board alleged that Petitioner issued prescriptions to M.O.

---

highly selected subgroup of over 3000 patients with chronic non-cancer pain seen in our unit during the period of the study. Usually this form of treatment would be adopted only when all other appropriate therapies have failed."

The study indicated that of these twelve patients, the spinal catheter was discontinued in five cases where the patients died, in three cases due to infection and in two cases where the patients experienced pain on injection/inadequate analgesia. Pain spontaneously resolved or the treatment was completed in the remaining two patients. This study cannot be read as recommending patient self injection for control of chronic non-cancer pain, and indeed the author acknowledges that this remains a controversial issue. (*Id.* at p. 219.)

and authorized refills of prescriptions for morphine in large quantities resulting in her becoming addicted to same.

As pointed out by the ALJ, the definition of addiction includes a behavioral component characterized by psychological dependence and aberrant drug related behaviors. (*See*, PROPOSED DECISION, Finding 7.) Physical dependence and tolerance are normal physiologic consequences of extended opioid therapy and are not the same as addiction. While M.O. experienced painful withdrawal symptoms associated with her physical dependence on morphine, it was not established that her dependence was psychological or that she exhibited other aberrant drug related behaviors. Therefore by accepted definition, M.O. was not an addict. It was also not established that Petitioner authorized refills of morphine for her. He continued to prescribe morphine each time her supply ran low, but this is different than authorizing refills.

At *Accusation Paragraph 28G* – Respondent Medical Board further alleged that after Petitioner realized that M.O. had become addicted to morphine, he provided her with methadone and Valium to help her with her dependence on the morphine.

For the reasons mentioned above and also found by the ALJ, it was not established that M.O. was addicted to morphine. Successfully weaning oneself off morphine and methadone is not evidence that one was addicted to same. This Court agrees with the finding of the ALJ in this regard.

At *Accusation Paragraphs 29 and 30* – Respondent Medical Board alleged more generally that Petitioner's

acts over the relevant period of M.O.'s treatment constituted gross negligence, repeated acts of negligence, incompetence or repeated acts of clearly excessive prescribing or administering of drugs (controlled substances and dangerous drugs).

With the exception of patient self-injection, Respondent did not prove the above allegations. It has failed to present clear and convincing evidence to a reasonable certainty that Petitioner's actions in treating M.O., though unusually aggressive, were in violation of the Code sections cited. (Business and Professions Code sections 2234 and 725.) The findings of the ALJ are sound and supported by the weight of the evidence adduced from this Court's independent review of the record.

At *Accusation Paragraph 32* – Respondent Medical Board further alleged that Petitioner's actions in furnishing a controlled substance(s) (morphine and methadone) to a known addict or habitue without legitimate medical purpose constitutes unprofessional conduct.

M.O. was not a known addict. Further, Petitioner did not provide her controlled substances solely for the purpose of providing her controlled substances sufficient to keep her comfortable by maintaining her customary use. Rather, he prescribed same with the good faith belief that her injury and pain required such treatment. It was not established that Petitioner's furnishing M.O. with controlled substances constituted unprofessional conduct in this case.

II. Patient M.G.

Third Cause For Disciplinary Action

Treatment History – Patient M.G.

a. During the period that Petitioner served as the Director of the Pain Clinic at Oak Knoll Naval Hospital in Oakland, he and his staff provided medical care and treatment for patient M.G. from October 1991, and continuing through the beginning of August 1993. The then 29 year old M.G. complained of chronic, acute and recurrent back pain. He had initially injured his back in 1988 while helping to unload a Medivac flight.

b. In June 1988, M.G. underwent a hemilaminectomy for decompression of his nerve root at L5 and S1. In December 1988, due to continued back pain, he underwent a second laminectomy which included a two level fusion (L4, L5 and S1) with a bone graft. He received some relief from his chronic back pain, but was subsequently hospitalized from July 22-24, 1991, due to spinal instability, low back pain and left leg pain. M.G. had also received five to six epidural steroid injections with limited relief of symptoms. He had no history of methadone use prior to being referred to Petitioner in late September/early October 1991.

c. The earliest record (Exhibit 39 – consultation sheet) of Petitioner's examination of M.G. states only that:

> "29 year old status post two level laminectomy and fusion, now with positional sharp pain and non union. Pain probably non-union related. Has failed epidural steroids in past times five.

Will try methadone – if fails consider diagnostic block."

There is no written record of Petitioner or his staff conducting a more extensive medical history or physical examination at the time of M.G.'s initial evaluation at the Oak Knoll Naval Hospital Pain Clinic. Navy medical protocol provides for one complete set of comprehensive medical records for patients, and these were not maintained at the pain clinic. They were not among the records retrieved by Respondent as part of the medical records offered at hearing. Petitioner notes that pain clinic records were never intended to be the complete records of everything done medically for patients at Oak Knoll, and are not the official records for M.G. He also maintains that an *adequate* history and physical examination were performed. He does not assert that a *complete* history and physical examination were done, or that such are a part of the official medical records maintained by the Navy.

d. Petitioner prescribed for M.G. a trial of methadone with good results. He initially prescribed 1-2 pills (5 mg) to be taken as needed every 6-8 hours. For the first month, one pill was enough to reduce M.G.'s pain, and then he upped it to two pills as prescribed. Petitioner prescribed no additional medications, adjunctive physical therapy or other treatment.

e. Over the one year period from October 1991 to October 1992, M.G. increased the amount of methadone he was taking from 1 to 20 pills per day. On October 19, 1992, M.G. underwent a third surgical back procedure, a

repeat transverse process fusion L4 to L5, and was discharged on October 27, 1992 in a full body cast. The cast was removed, refitted, and removed again in January 1993. Over the period of his rehabilitation, M.G. continued on methadone, upping his daily intake to 30 pills, and then perhaps to as much as 35 to 40 pills per day. He would typically have an appointment with Petitioner or his staff every seventeen days, and use such occasions to get refills in excess of the prescribed monthly dosage. Patient M.G. testified at the hearing that he would lie to Petitioner about losing pills. He also lied to Petitioner about how much methadone he was taking. Petitioner testified that he believed that M.G. was taking 20 pills/day, based upon M.G.'s misrepresentations. Petitioner attempted to taper M.G. down to 15 pills/day, not knowing that M.G. was already up to 30 pills/day, and not 20. Petitioner also tried non-narcotic analgesics without success. Lidocaine injections did not provide lasting relief, and other medications upset M.G.'s stomach.

f. M.G. became increasingly concerned over his dependence upon methadone. As he experienced more difficulty and agitation trying to taper down the methadone, he was admitted to the Oak Knoll Naval Hospital for methadone withdrawal. This was apparently his third withdrawal attempt. The plan was to decrease his daily methadone by 10 mg per day. At the time of his discharge on August 5, 1993, he had been off methadone for two days, and had been accepted into a prescription drug rehabilitation program.

g. On August 5, 1993, he was transferred to CPC Fremont Hospital for continued in-patient prescription drug rehabilitation therapy. His diagnosis at that time

was opiate withdrawal, opiate dependence; rule out major depression. He was started on a detoxification protocol using Buprenex and Valium, and he then left against medical advice on August 7, 1993. He returned on August 9, 1993 recommenced the detoxification protocol, and was discharged on August 17, 1993 with plans for followup care. He has remained free of methadone. As a part of his rehabilitation therapy, M.G. testified that he views himself as an addict, and believes that he was made so by Petitioner.

Accusation Allegations – Patient M.G.

At *First Supp. Accusation Paragraphs 12A-12E* – Respondent Medical Board alleged that Petitioner failed to perform a complete history and physical examination; and by failing to perform same could not initiate a treatment plan noting what objective factors would be used to evaluate the success of the treatment; and by failing to institute a treatment plan could not evaluate the patient at periodic intervals using the original history and physical as a baseline.

The ALJ found that Board guidelines call only for a diagnostic examination and an adequate medical history. Both are directed at arriving at a diagnosis and treatment plan. The ALJ further found that it is not necessary that a complete history and physical examination be performed in every case, particularly when patients are being referred by a primary physician for specific medical procedures or pain management. The history and examination need only be adequate for the purposes referred.

Dr. Levin, one of the Respondent's physician experts, opined after review of M.G.'s records that the failure to do a complete history and physical exam initially, and the failure to evaluate the patient thoroughly at each return visit, constitutes a departure from the standard of practice of medicine. He did not find such departure to be extreme. Petitioner admitted to performing an abbreviated physical examination, but avers that such was adequate for the purpose of addressing M.G.'s specific complaints of pain. He also noted that the pain clinic records were not the official Navy medical records for M.G., and that he recorded detail sufficient only to jog his own memory and to guide his future treatment.

The ALJ found that a major deficiency in Petitioner's pain clinic records for M.G. is the lack of a specific treatment plan. There was not enough information charted to provide a reviewing physician an understanding of Petitioner's thought process or the treatment plan and course. What often purports to be a treatment plan (e.g., "will try methadone – if fails consider diagnostic block.") is too abbreviated and incomplete. (*See*, PROPOSED DECISION, Finding 22c.) The ALJ also found that too much was made of the fact that Petitioner's pain clinic records were not official Navy records. It was also noted that Petitioner did not also argue that a treatment plan would be expected to appear in the official Navy medical records. The ALJ found that it would reasonably be expected to appear in Petitioner's pain clinic records, and it does not. Because Petitioner is aware of what is required, and indeed he complies with these requirements in other cases reviewed; and because the departure

is not substantial, it was not established that his departure from the standard of practice constituted either incompetence or gross negligence on his part. His conduct did demonstrate negligence. These findings of the ALJ are supported by the weight of the evidence.

First Supp. Accusation Paragraph 12F – Respondent Medical Board alleges that Petitioner's failure to use other medications or treatment modalities constituted negligence, gross negligence or incompetence. Accusation allegations specifically reference the failure to consider treatment modalities for neuropathic pain such as tricyclic antidepressants, antiseizure medications, physical therapy to improve range of motion and muscle strength and psychological counseling and support if available.

There is no evidence that M.G. had neuropathic pain. Physical therapy was being managed for M.G. through his surgeon and Petitioner considered it improper for him to intervene. Psychological counseling was sought and ongoing. These Accusation allegations were not established.

First Supp. Accusation Paragraph 12G – Respondent Medical Board alleged that Petitioner incompetently and/or negligently and/or grossly negligently taught, encouraged and/or allowed patient M.G. to self-administer methadone, on an as needed basis.

Board expert Dr. Levin opined that in prescribing methadone for chronic pain patients, the patient should be allowed to take the narcotic on a time-dependent rather than a pain-dependent dosing schedule. He believes that the dose should be rigidly dictated by the

physician, and not by the patient. Here, Petitioner prescribed 1-2 pills of methadone (5 mg) to be taken as needed every 6-8 hours. Dr. Levin believes that the dose should instead have been a fixed amount to be taken every six or eight hours. His rationale is that methadone is a well-absorbed oral narcotic with a long half life, and because of this it needs to be maintained in the bloodstream at a fairly constant level. The regular timing of doses also gets away from problems of patient psychological dependence on short acting narcotics.

Petitioner agrees in principle that methadone should be taken on a time dependent basis, but feels that Dr. Levin's approach is too dogmatic and not the standard of care. There should be some allowance for flexibility, and he believes that setting the outer parameters of a dose (e.g., 1-2 pills every 6 to 8 hours) is within the standard of care. In support, Petitioner offered a recommended table for methadone administration contained in the September 1995 edition of *Anesthesiology News* (Exhibit X) which offers the following comment: "dosing should start on prn [as needed] basis with close monitoring."

Regardless of whether it is better to be on a strict time dependent basis, it appears that the general practice has been mixed, with both approaches finding support. Petitioner does define the outer parameters for methadone intake by amount and time so that it is not prescribed on an absolute as needed basis. His methadone dosing is subject to an element of physician control, albeit not strict. It is also consistent with his philosophy of patient autonomy and participation in pain management. For these several reasons, the ALJ found that it was not improper for Petitioner to prescribe methadone as he did

to M.G. on an as needed basis within the stated parameters of amount and time. This finding is also supported by the weight of the evidence.

First Supp. Accusation Paragraph 13 – Respondent Medical Board alleged generally that Petitioner's actions in treating M.G. over the relevant period constituted repeated acts of negligence, gross negligence, or incompetence. The thrust of the charges look to whether Petitioner caused M.G. to become addicted.

Unlike the previous matter of patient M.O., here the psychological element appears to be present. Within months of beginning the medication program M.G. began lying to other physicians in an effort to secure additional methadone. He went to the V.A. Hospital in Palo Alto to get more methadone and made up a story about who was treating him in order to protect Petitioner. When his intake of methadone escalated to between 35 and 40 pills per day, he was reporting to Petitioner and his associates at Oak Knoll Naval Hospital that he was only taking half that amount. He also lied about losing the pills when he had not in order to obtain another month's supply. The efforts to enroll and then maintain him in a detoxification program also point to his dependency problem. Even while recognizing that he was experiencing severe difficulties in attempting to control his methadone intake, M.G.'s own attempts to stop the methadone or to taper it were complicated by violent behavior, diarrhea and nausea.

It was therefore fairly established that M.G. became addicted over time to methadone, and that intensive measures were needed to wean him off methadone and then

to keep him off. As pointed out by the ALJ, the more difficult issue is whether Petitioner's practices in prescribing him methadone over this period were within the standard of care. Board expert witness Dr. Michael Levin opined that Petitioner did *not* make M.G. an addict. (RT 1/10/96, p.19) He also was not as concerned about the amount of methadone prescribed to M.G. as he was about the fact that it was done so on an as needed basis. In his October 9, 1994 report to the Board, Dr. Levin finds many elements around M.G.'s treatment to criticize, but he does not find that Petitioner's actions contributed to his becoming an addict. His criticisms around methadone administration, relate only to the prn dosing and Petitioner's failure to use other adjunctive medications prior to the institution of long term narcotics.

Although M.G. did become addicted, there is no evidence that Petitioner was on notice that he was exhibiting drug seeking or other aberrant behavior as above described. He made a good faith determination that M.G. was suffering from an injury which required such treatment. There was objective evidence of his pain following nonunion of his spine. Petitioner reasonably relied upon M.G.'s reports of methadone intake, which turned out to be only a fraction of what he was actually taking. That M.G. was seeing several of Petitioner's associates at the Navy clinic further complicated Petitioner's ability to adequately monitor M.G.'s drug seeking behavior. In hindsight it is clear that M.G. was addicted. But at the time methadone prescriptions were made, they were done in good faith and in amounts believed necessary to address M.G.'s pain. They were not merely prescribed to keep M.G. comfortable or to maintain his customary use.

Most important, the Board's own medical expert apparently does not believe that Petitioner made M.G. an addict.

To the extent that Petitioner was negligent over the relevant period, such relates primarily to his failure to institute an objective, measurable treatment plan against which future progress could be gauged at periodic intervals. It was not established that his conduct in administering methadone demonstrated repeated negligent acts, gross negligence or incompetence.

First Supp. Accusation Paragraph 14 – Respondent Medical Board further alleged that Petitioner's actions constitute repeated acts of clearly excessive prescribing or administering of drugs (methadone).

By reason of the matter set forth in the ALJ's Findings 25 and 26, and also accepted by this Court to be true, it was not established that Petitioner's prescribing of methadone to M.G. on an as needed basis, or at a time that he began exhibiting drug seeking and other aberrant behavior, was improper. Petitioner acted in good faith upon the information reasonably available to him at the time. Apparently, M.G. was a convincing patient. The fact that he had other measurable and objective medical findings certainly did not hurt his case for pain. He reasonably appeared to Petitioner as an intractable pain patient, and was treated accordingly. The fact that Petitioner and others were ultimately duped into providing M.G. additional methadone does not transform their actions into clearly excessive prescribing or administering of controlled substances (methadone). The ALJ found, and this Court agrees, that this allegation was not established.

III. Patient M.H.

Fourth Cause For Disciplinary Action

Treatment History – Patient M.H.

a. Petitioner first saw patient M.H. on January 29, 1993. She was then age 39, and presented with complaints of dull throbbing ache with an occasional sharp stabbing pain primarily in her back and occasionally down her legs. Her pain related back to a motor vehicle accident in April 1983. She had been followed by several physicians and had been treated in the past with Vicodin, anti-inflammatory and epidural blocks (7-8 epidural steroid injections), acupuncture and chiropractic. At the time of her first visit with Petitioner, M.H. was taking medications including Mellaril, Doral and Zoloft. She had not undergone any surgical intervention before seeing Petitioner. She reported her pain to be a 7 on a 0-10 scale. M.H. had been referred to Petitioner by Jeffrey White, M.D. for evaluation and treatment of severe recalcitrant low back pain with occasional leg pain, especially for consideration of an implanted intraspinal narcotic infusion pump.

b. She had a documented history of psychosis, depression and suicidal ideation as well as multiple actual suicide attempts. She also had undergone electroshock therapy. It was reported to Petitioner that she had used cocaine recreationally about a year prior to seeing him, but that she was no longer using street drugs. Petitioner considered her to be a complex patient and given her psychological history including past suicide attempts, he expressed concern to Dr. White that "she might be having such high expectations for me that a failure on my

part to help her might cause her to seriously consider suicide again." (Exhibit 50)

c. Over the period February 1 to February 16, 1993, M.H. saw Petitioner for six office visits. On February 2, Petitioner performed a spinal block using a local anesthetic (Lidocaine 50 mg) and a short acting narcotic (Fentanyl 50 mcg) which M.H. tolerated well and which provided complete pain relief. On February 3, M.H. was seen in Petitioner's office by his associate Mark Lemons, M.D. He performed a second spinal block using Lidocaine (50 mg) and Fentanyl (100 mcg) which she tolerated well, except for an allergic reaction (pruritus) treated with Benadryl.

d. On February 4, Petitioner, noting that there was no overall incremental improvement, performed a diagnostic intravenous Lidocaine infusion, beginning with 50 mg with an additional 150 mg for a total of 200 mg. This was followed by a trial prescription of Mexiletine.

e. On February 8, 1993 Petitioner noted that M.H. did not tolerate the Mexiletine. He decided to give her a methadone trial, starting her on 1 to 2 tablets (5 mg) every 4 to 12 hours as needed for pain. A total of 50 tablets were prescribed. He discussed the need to titrate her dosage upward to her needs. A followup visit was scheduled for the next week.

f. On February 16, 1993 M.H. reported to Petitioner that she had been taking two methadone every four hours, and that it had essentially no effect on her pain. Petitioner noted that M.H. reported a previous history of

street drug use, primarily cocaine, which could be affecting her tolerance. Petitioner also noted that M.H [sic].'s psychologist was pleased by her progress. He averd that her psychologist gave M.H. a note to give to Petitioner, asking him to consider the possibility of facet injections. Given her very low L-5/S-1 area tenderness, Petitioner felt that a facet block might be given future consideration. At the end of the visit Petitioner again prescribed methadone, 3 to 4 tablets every 4 to 6 hours as needed for pain. A total of 200 tablets were prescribed, making available to her 1,000 mg of methadone. His treatment plan consisted of increasing her methadone, reevaluating her based on this increased dosage, and having her return with imaging scans of her back for consideration of placement of an indwelling narcotic infusion pump.

g. On February 19, 1993 M.H. was found, unconscious and unresponsive in her apartment. She was brought to the emergency room and admitted to Humana Hospital in San Leandro with an admitting diagnosis of presumed phenothiazine and methadone overdose and probable aspiration pneumonia. Her long psychiatric history and multiple suicide attempts were also noted in the admitting report. On the night before she was hospitalized, M.H. recalls taking only two medications, Mellaril and methadone. It was not established that any overdose was intentional or otherwise a suicide attempt by M.H. The two drugs taken in combination may have the effect of potentiating each other. The additional methadone that she took in combination with the Mellaril may have had a respiratory depressant effect.

h. She recalls taking the methadone, and then taking some more per Petitioner's instructions that she

should take the medication "as needed" for pain. The physician who followed her after admission, Eugenio L. Balbuena, M.D. noted in his history that the bottle of methadone was found to be full, so it does not appear that she took an excessive dose. Also, M.H. was twice administered Narcan, a drug that reverses the effects of a narcotics overdose, with no change in her level of consciousness. While it was theorized that her unconsciousness may have instead been due to hypoxia from aspiration pneumonia, which condition would not respond to Narcan, it still does not appear that M.H. intentionally overdosed on methadone.

Accusation Allegations – Patient M.H.

At *First Supp. Accusation Paragraphs 26A/B* – Respondent Medical Board alleged that Petitioner incompetently and/or negligently and/or grossly negligently taught, encouraged and/or allowed patient M.H. to self-administer methadone, on an as needed basis.

Respondent argued at the administrative hearing that it should have been prescribed in a stated milligram dose every six or eight hours. Board medical expert Dr. Michael Levin made much the same argument with respect to patient M.G. *See*, PROPOSED DECISION, Finding 25) and it was determined there that methadone could properly be prescribed on an as needed basis within stated parameters of amount and time. However, Dr. Levin also points out that where a patient like M.H. has a known history of addiction to cocaine and street drug use within the previous year, there is more reason not to give her access to prn (as needed) medications. The

ALJ found, and this Court agrees, that this reasoning is sound.

Petitioner argued that patients should be free to adjust doses upward as activity levels increase or as tolerance develops. The fact that she had a history of suicide attempts was a factor to be considered, but only, as the ALJ pointed out, on the threshold issue of whether or not she was currently at risk for suicide. Even still, where a patient presents with a known history of both past cocaine/street drug use and past attempts at suicide, a physician is bound to assume far greater monitoring and control of methadone prescription. Certainly, Petitioner could titrate doses upward as tolerance or activity levels increased. As adduced during the expert testimony, there are clearly ways that he could be responsive to changes in her need for methadone. For these reasons, the ALJ stated that Petitioner's practice in giving M.H. methadone on a prn basis was a departure from the standard of care (negligence). Further, the ALJ found that it was not an extreme departure from the standard of care (gross negligence), nor does it reflect physician incompetence or lack or knowledge or understanding of the pharmacology of methadone. An independent review of the record by the Court finds that the weight of the evidence supports these findings.

At *First Supp. Accusation Paragraph 26C* – Respondent Medical Board also alleged that Petitioner caused M.H. to undergo, without medical indication or justification, two spinal anesthetics with local anesthetic and narcotic; procedures without any diagnostic or therapeutic value. One of the two procedures was actually done by Dr. Mark Lemons in Petitioner's office. Board expert, Dr. Levin,

opines that if the test was for purposes of evaluating future implantation of a narcotic infusion pump, such should be done with a narcotic alone. By combining two agents, one cannot tell which is providing the pain relief.

Petitioner testifed that the combination block does have diagnostic value. The local anesthetic has a very fast onset and will give indication if the patient has sympathetically maintained pain. If the pain is sympathetically maintained, according to Petitioner, one would expect to see a total relief, followed by a return of the pain and duration to a somewhat diminished level. The duration of pain relief may be upwards of three to four days from local anesthetic. If the pain returns within hours or with the same intensity one day later, it points to the narcotic as the active agent for pain relief.

Here, Petitioner performed the block for purposes of evaluating M.H. for possible narcotic infusion pump, to determine whether there was any long term benefit from such block, and to see if her pain was neuropathic or sympathetically maintained. The ALJ found, and the Court agrees, that it was established that the blocks were performed for diagnostic purposes, and therefore were not an extreme departure from the standard of care.

At *First Supp. Accusation Paragraph 27* – Respondent Medical Board further alleged that the course of treatment and professional care provided to M.H. constitutes gross negligence, repeated acts of negligence or incompetence.

Petitioner was aware of M.H.'s relevant recent psychological history. In his February 14, 1993 letter to Dr.

White (Exhibit 50) he expressed specific concerns regarding her psychological state. He recalls contacting her psychiatrist, Dr. Scott, and references same in a separate letter to the sister of M.H. He also references her street drug use in the February 16 progress note, along with a reference to a recommendation by a psychologist that "Versed" (read facet) injections be considered. Respondent Medical Board attempted to lay responsibility for M.H.'s overdose on Petitioner. The record is not clear as to whether M.H.'s overdose was intentional, or whether it was even attributable to an overdose of methadone. (*See*, PROPOSED DECISION, Findings 28g and h.) Because the evidence demonstrates that methadone and Mellaril potentiate the effects of the other, it was found by the ALJ that it could be that her overdose was accidental. Regardless, even Board expert Dr. Levin indicated that he did not focus on this incident, and that he did not see this as a major problem that Petitioner had contributed to.

As previously stated, Petitioner's negligent treatment of M.H. relates primarily to his prn dosing of methadone for reasons already set forth above.

At *First Supp. Accusation Paragraph 28* – Respondent Medical Board also alleged that Petitioner's use of spinal anesthetics constituted repeated acts of clearly excessive use of diagnostic or treatment procedures.

There were only two spinal blocks, only one of which was performed by Petitioner. For reasons already discussed, these procedures did not constitute repeated acts of clearly excessive use of diagnostic or treatment procedures.

IV. Patient B.C.

Fifth Cause For Disciplinary Action

Treatment History – Patient B.C.

a. Patient B.C. was a 37 year old man with a history of cat scratch fever, resulting in the removal of cysts on the left side of his neck. Following partial removal of the cysts, first in 1987, and again in 1988 for a recurrent mass, B.C. experienced pain (chronic trigeminal neuralgia) and was treated for same at Kaiser. Eventually, Kaiser physicians Dr. Golfus and Dr. Matus referred him to Petitioner for an initial diagnostic block and further evaluation/ treatment of his symptoms. This was on February 1, 1990. By then he had already undergone a number or [sic] treatments with physicians and therapists without effect.

b. On his first visit, B.C. completed a fairly extensive medical history on a form utilized by Petitioner's pain relief center. Petitioner did not perform a physical examination because B.C. was referred to him for a particular procedure, and Petitioner viewed his role as an information gatherer and consultant for the Kaiser physicians. The relevant treatment history between February and April 1990 is well summarized in Exhibit 71 and follows:

> "On February 1, 1990, the patient underwent thoracic epidural anesthetic with 0.5% Lidocaine, experiencing complete relief of his pain symptoms. Dr. Day made the diagnosis of sympathetic dystrophy. On February 2, 1990, he underwent repeat thoracic anesthetic, however there was still pain in the left neck and he underwent trigger point injections which relieved his pain completely. On February 8,

1990, he underwent another thoracic epidural anesthetic. He was not seen again until March 27, 1990, having undergone a neuroma excision during that time. His pain was not improved. On March 27, 1990, he underwent left stellate ganglion block with 5 mg morphine in addition to 10 cc 1% Lidocaine and experienced relief. On March 28, 1990, he again underwent left stellate ganglion block with Lidocaine and morphine. On March 29, 1990, he underwent epidural thoracic catheter placement with injection of 0.5% Lidocaine, 50 mg Demerol, and 80 mg Depo-Medrol.

On April 2, 1990, it was noted that he received six hours of pain relief from the Demerol injection. He underwent thoracic epidural catheter placement again and was injected with 5 mg morphine and 5 cc 0.5% Lidocaine, which was then repeated 30 minutes later. He was discharged home following the thoracic epidural injection of morphine. On April 3, 1990, the patient returned, noting 10 hours of relief following the epidural morphine injections."

c. On April 10, 1990, Petitioner wrote to Dr. Matus and suggested three treatment options for B.C. Treatments up until then provided relief for only a short period of time, and the absence of any incremental improvement prompted Petitioner to suggest that the following be considered: 1) a neurolytic stellate ganglion block, 2) a surgical stellate ganglionectomy or 3) an implanted intraspinal narcotic infusion pump. With regard to the narcotic infusion pump, Petitioner did not feel he should really consider this alternative until B.C. was evaluated by a surgeon, or B.C. had refused surgery or had failed to obtain adequate relief following surgery.

d. On October 2, 1990, Petitioner performed Phenol trigger point therapy by injecting a small amount of 0.5.% Marcaine into the scar on B.C.'s neck. The procedure was repeated after a half hour with 1 cc of 6% aqueous Phenol solution. B.C. obtained good but not complete pain relief. On October 8, the procedure was repeated with injection into the subcutaneous tissues deep into the scar on the left side of B.C.'s neck.

e. B.C. was also seen at the UC Davis Neurosurgery Department and had both a dorsal root rhizotomy and an intraspinal narcotic infusion pump recommended. About this time Petitioner was called to active duty at the Oakland Naval Hospital during Operation Desert Shield and had advised B.C. to consult his primary care physician for ongoing and followup care.

f. On December 6, 1991, at the request of B.C. and in order to have Kaiser medical plan cover the costs associated with the surgery, B.C. was admitted to Kaiser Hospital in Vallejo for the attempted insertion of an intrathecal narcotic infusion pump by Petitioner. The procedure was done under general anesthesia. A small incision was made at the T5-T6 [thoracic] interspace and multiple unsuccessful attempts were made to enter the intraspinal space. A 14 gauge epidural needle was used. Petitioner then moved one space further up where again, multiple unsuccessful attempts were made. Both a 14 and 22 gauge epidural needle were used to enter the intraspinal space. A further incision was made to join the two sites and to deepen the incision in order to allow attempts to enter the subarachnoid space. Multiple attempts were again unsuccessful.

g. Petitioner then attempted entry from various positions, including midline and to the right of the paramedian approach, without success. On one occasion when Petitioner felt that the subarachnoid area had been entered, he retrieved free flowing bloody fluid. B.C. developed bigeminy and the anesthesiologist had to administer Lidocaine to return him to a normal sinus rhythm. Petitioner next attempted to enter the subarachnoid space in the lumbar area and inserted a 22 gauge needle at the L1-L2 area where he obtained grossly bloody fluid. The attempted procedure was thereafter aborted. At no time during the procedure did Petitioner use fluoroscopy.

h. As a result of the above described operation, B.C. suffered catastrophic complications. These included pneumothorax, epidural bleeding, and postoperative lower extremity paralysis. An emergency MRI revealed evidence of a small spinal cord contusion at the thoracic level. B.C. remained hospitalized for eleven days before he was discharged with home nursing care and physical therapy for his paresthesia.

Accusation Allegations – Patient B.C.

At *First Supp. Accusation Paragraphs 45A-E* – Respondent Medical Board alleged that Petitioner failed to perform a complete history and physical examination, did not initiate a treatment plan noting what objective factors would be used to evaluate the success of the treatment, and did not evaluate the patient at periodic intervals, using the original history and physical as a baseline.

An adequate history was obtained. (*See*, PROPOSED DECISION, Finding 33b) Board expert Dr. Levin was

shown relevant portions of B.C.'s medical records and, contrary to his earlier written report, he now opines that an adequate history and physical examination were performed. B.C. was referred to Petitioner for specific procedures – initial diagnostic block and further evaluation and treatment of his symptoms. Under these circumstances, all that was necessary by way of history and physical examination is confirmation that the requested procedure is reasonable. That was done here. There was an initial history and physical taken by Petitioner that could later be used as a baseline. Petitioner did not consider himself as B.C.'s primary treating physician and the overall treatment plan for B.C. was the responsibility of his Kaiser primary physician. The ALJ found, and this Court agrees, that these Accusation allegations were not proven.

At *First Supp. Accusation Paragraph 45F* – Respondent Medical Board next alleged that prior to proceeding with a narcotic infusion pump Petitioner failed to use other medication trials or treatment modalities. Examples offered were tricyclic antidepressants, antiseizure medications, antiarrhythmic medications, Capsaicin cream, oral narcotic or physical therapy to improve range of motion and muscle strength, and psychological counseling and support.

Petitioner again pointed out that he was not the primary care physician, and that this was not his role. Something more than conservative pain management was sought for B.C. For this same patient, two other physicians after a single visit recommended in one case a aeurosurgical procedure without any trials, and in the other case implantation of electrodes in the brain.

Petitioner presented the three more aggressive interventions (*See*, PROPOSED DECISION, Finding 33c) only after it was apparent that treatment up until then provided only temporary relief with no incremental improvement. B.C. did undergo psychological counseling in reference to recommended procedures. For these reasons, the ALJ found, and this Court agrees, these allegations were not sustained.

At *First Supp. Accusation Paragraph 45G* – Respondent Medical Board further alleged that Petitioner's manner of using combination (morphine plus Lidocaine) blocks made any diagnosis derived from same suspect.

Board expert, Dr. Levin opines that morphine clouds the diagnostic picture when used in a diagnostic stellate ganglion block and makes the test of no value. Petitioner explained that the diagnosis of pain is easily distinguished at that level, and that because he had earlier made the diagnosis prior to the use of morphine, the addition of morphine was meant to be therapeutic, not diagnostic. The diagnosis was considered easy to make in this case because of the substantial anatomical separation of the sympathetic (T2-T4) and sensory nerves (C2-4). The ALJ found Petitioner's reasoning is rational. This Court agrees that it was not established that his use of combination blocks departed from the standard of care.

At *First Supp. Accusation Paragraph 45H* – Respondent Medical Board alleged that there was no clear indication for using steroids for B.C.'s condition, and also that Petitioner administered high doses of oral or intravenous narcotics without appropriate respiratory monitoring.

Epidural steroids are acceptable for treatment of sympathetic pain syndromes, and Petitioner had initially diagnosed sympathetic dystrophy (*See*, PROPOSED DECISION, Finding 33b). Thus, his use of epidural steroids was not inappropriate.

Petitioner gave B.C. the narcotic antagonist Naltrexone on March 23, but not on March 27 or 28, 1990. His reasoning is that B.C. was either given oral Naltrexone or otherwise demonstrated insensitivity to narcotics. Dr. Levin opines that patients should have hourly respiratory checks for 24 hours following epidural narcotic injections. It was not established that Petitioner's use of Naltrexone and clinical observations following epidural narcotic injections were outside the standard of care.

At *First Supp. Accusation Paragraph 45I* – This allegation relates to matters previously discussed. (*See*, PROPOSED DECISION, Findings 30 and 36.) Petitioner's use of combination blocks (narcotic and local anesthetic) as a diagnostic test prior to consideration of an intrathecal narcotic infusion pump was not outside the standard of care.

At *First Supp. Accusation Paragraph 45J* – Respondent Medical Board alleged that Petitioner's decision to attempt to place an intrathecal narcotic pump was premature given the lack of more conservative measures.

As pointed out by the ALJ, this decision was made by B.C. in conjunction with his primary care physician. B.C. also had psychological counseling specifically related to this procedure before it was approved by his primary care physician. Petitioner did not even see B.C. for the year preceding the procedure, during which time he had

advised B.C. to consult his primary care physician for ongoing and followup care. This Accusation allegation was not established.

At *First Supp. Accusation Paragraph 45K* – Respondent Medical Board alleged that Petitioner's decision to place the infusion catheter at the thoracic level demonstrated a lack of knowledge of both how the catheter is inserted and how intrathecal morphine circulates in the cerebral spinal fluid. The allegations were based on Dr. Levin's opinion (Exhibit 71) which follows:

> "Intrathecal morphine is hydrophilic, meaning that it will circulate freely in the cerebrospinal fluid. Narcotic infused at the lumbar level, where it is much safer to place the catheter, would achieve the same concentration at the thoracic level as a catheter placed at that level. Furthermore, the catheters are designed to be threaded from the lumbar region below the spinal cord upwards under fluoroscopy, so that if it was necessary to place a catheter at the thoracic level, it should have been done from an insertion point at the lumbar level. If Dr. Day felt that it was necessary to place the catheter through a thoracic entrance site, as he did, then it should never have been performed under general anesthetic. Fluoroscopy should have been utilized for assisting placing of a needle. . . . When placed correctly in the lumbar region, for the correct indications, under local anesthesia, it is a very safe procedure."

Petitioner testified that he believes that upper thoracic placement was important because of the need to have morphine diffuse directly into the level where it would work. He suggests that lumbar placement of the

catheter leads to concentration of narcotic in the sacral portion of the spinal cord leading to possible urinary retention. He also believes that threading the catheter upwards with the stilette runs a risk of damaging nerves along the spinal cord leading to injury. Petitioner also testified that the catheter has a lower specific gravity than cerebrospinal fluid and that it would tend to drift down over time, with nothing to support it once the stilette is removed. Finally, Petitioner views fluoroscopy as something causing more interference than help. He maintained that there is a risk of radiation damage to metabolically active sites (e.g., bone marrow). He did not believe it to be useful. He also believes that under a straight risk/benefit analysis, there was less danger of hitting and damaging the spinal cord at the thoracic than lumbar level.

As pointed out by the ALJ in his PROPOSED DECISION, Dr. Levin's medical opinion is more persuasive. Although morphine may not be completely hydrophilic, i.e.; described as like pouring cream into coffee, it will reach equilibrium state over time in the cerebrospinal fluid, and if threaded upwards from the lumbar region, it will more closely approximate thoracic placement. Lumbar placement is safer and experience indicates that excellent relief can be gotten in the upper extremities from same. Given the greater risks associated with thoracic placement, fluoroscopy should have been utilized. It would have been an additional safeguard against the possibility of pneumothorax, and would have indicated when the needle was approaching the intrathecal space. Petitioner's actions without fluoroscopy resulted in pneumothorax (collapsed lung), epidural bleeding and

postoperative lower extremity paralysis (*See*, PROPOSED DECISION, Findings 33f-h).

By reason of the above, the ALJ found, and this Court agrees, it was established that Petitioner's decision to place the infusion catheter at the thoracic level and without the use of fluoroscopy represented an extreme departure from the standard of care. It also exhibited a lack of knowledge and ability in carrying out his professional medical obligations. The findings of the ALJ in these matters are supported by the weight of the evidence.

At *First Supp. Accusation Paragraph 45L* – Respondent Medical Board also alleged that placement of the intrathecal infusion pump under general anesthesia was also a departure from the standard of care. Board expert, Dr. Levin opines that general anesthesia is not generally used for this procedure because a patient's response is needed to determine whether any neural structures are being irritated.

Petitioner testified that he had performed similar procedures under general anesthesia with the assistance of another physician. He has also performed comparable procedures under local anesthetic. At no time was he told that it was either inappropriate or dangerous to perform such under general anesthesia. In this case, he believes that it would have made no difference if B.C. had been awake. The injury to his spinal cord would still have occurred. It may have been the better practice to perform this procedure under local anesthetic, but it was not established that Petitioner's use of general anesthesia, taken alone, was an extreme departure from the standard of care or that it reflected incompetence on his part. It

was a departure from the standard of care and therefore constituted negligence. However, the ALJ found, and this Court agrees, that in combination with attempted thoracic placement of the intrathecal infusion pump without fluoroscopy, it constituted an extreme departure from the standard of care. The findings of the ALJ in this regard are supported by the weight of the evidence.

At *First Supp. Accusation Paragraph 46* – All of the general allegations of gross negligence, negligence or incompetence have been addressed above. The ALJ found that only First Supplemental Accusation paragraphs 45K and 45L were sustained regarding Petitioner's attempted placement of an intrathecal infusion pump at the thoracic level without the use of fluoroscopy and under general anesthesia. The weight of the evidence supports the findings that such action constituted gross negligence and exhibited a lack of knowledge and ability in carrying out his professional medical obligations.

V. Patient J.W.

Sixth Cause For Disciplinary Action

Treatment History – Patient J.W.

a. On August 28, 1986, Petitioner first saw patient J.W., a then 34 year old female with complaints of chronic, acute and recurrent pain in her left foot and leg. She had injured her left knee in September 1979, and had since had numerous surgeries including a surgical fusion of her left knee joint, reportedly as a pain control measure. A patient history was taken and a physical examination performed by office staff. (Exhibit FF) In his August 28, 1986 progress report, Petitioner noted:

"She is a 32 year old female who has a long history of sympathetic dystrophy of the left leg. This has been well evaluated and aggressively treated in the past.

She has received numerous sympathetic blocks in the past. These resulted in relief of pain in the leg, but she has never gotten long term relief from these injections. She has also received intravenous regional Reserpine with relief of the pain, but again, no long term relief.

She has had epidural steroids in the past, and this has not given her any long term relief. She is a good candidate for a neurolytic injection, but before I do that, I need to document for myself that she does not receive relief from a series of local anesthetic injections, and that she can get good relief with a sympathetic block."

b. Beginning on September 2, 1986 Petitioner began a course of treatment at the Walnut Creek Pain Relief Center consisting of daily nerve blocks via epidural catheter of 0.5% Lidocaine with DepoMedrol. The blocks provided limited relief. She was also started on methadone and Minipres, a medication described as helping to alleviate sympathetic dystrophies. Petitioner did not recommend adjunctive physical therapy because her knee joint was fused and she had full function of her leg in that condition.

c. On September 12, 1986, Petitioner decided to proceed with further epidural sympathetic nerve blocks, and these continued intermittently, mixed with DepoMedrol, through November 7, 1986. Methadone was prescribed on a time contingent dosing basis, but she was instructed within these parameters to take it until pain relief was

achieved. Petitioner was aware that J.W. was seeing a psychiatrist at this time.

d. In October 1986, Soma (350 mg) three times daily was added to the methadone. Petitioner noted in his October 28, 1986 progress report the following:

> "She also asked for some more methadone. I prescribed 100 tablets for her 6 days ago. She states that she takes on the average, 10 per day but she doesn't keep that close track of them. Looking back, her needs have been about 14 per day. This is a significantly large amount of methadone although she has been on narcotics for a very long time and has obviously developed a tolerance to them. We are obviously not going to be able to change this until we get control of her pain and I feel we are moving in that direction."

e. On November 12, 1986 a left neurolytic sympathetic block was recommended by Petitioner. There had been a previous recommendation for a neurolytic block but her psychiatrist had recommended this not be done. He noted that an intravenous regional sympathetic block using Reserpine gave her about one week of pain relief.

f. In early 1987, J.W. underwent a sympathicectomy of her left leg at Stanford Hospital. Petitioner did not see her again until August 6, 1987. He noted some improvement in her pain symptoms, but "certainly not a substantial or complete relief." She had been able to cut down substantially on her pain medication, but her pain continued to be a problem for her. Petitioner opined that there were two options remaining for her, spinal cord stimulation or an epidural narcotic injection. He describes the

former as a "glorified TENS unit" and avers that in 1987 it was not clear that such provided any substantial relief, and was very costly besides. He went forward with placement of a lumbar epidural catheter, injecting 50 mg of Demerol in 5 cc 0.5% Lidocaine. It resulted in complete relief. The catheter was left in place and J.W. was scheduled to return the next day for a trial of Duramorph, which she received.

g. On August 11, 1987, Petitioner taught J.W. to self-inject narcotics through the catheter port as an outpatient. After returning the next day for a demonstration she was discharged with supplies and Duramorph for self-injection for one week. She thereafter continued to self-inject narcotics through early May 1988. Over that period, J.W. also underwent numerous placements of the epidural portion of the Dupen catheter.

h. On March 17, 1988, a lumbar epidural catheter was placed, however, it was placed subarachnoid rather than epidurally. The March 18 progress report notes that:

> "[S]he is getting excellent relief with the subarachnoid injections and feels that the pain relief is even more profound than she gets with the epidural injections. In view of this response, we will leave the catheter in place and she will inject that [catheter] and we will consider very early next week for changing her to a more permanent subarachnoid catheter."

i. On March 23, 1988, J.W. was having persistent leakage of cerebral spinal fluid (CSF) out of the catheter. Petitioner noted that she was getting ineffective pain relief probably because of the loss of fluid, and that she was not feeling well secondary to withdrawal symptoms

associated with the leakage. The catheter was removed and CSF leakage spontaneously stopped. A midlumbar epidural catheter was placed and she was injected with 10 mg of morphine.

j. Between March 23 and May 6, 1988, J.W. experienced multiple problems with both temporary and permanent epidural catheters placed by Petitioner. These problems included headaches and marked changes in mental status. The tip of the epidural catheter was either placed in the wrong space or it had migrated out of place causing the problems experienced by J.W. On April 19, 1988, Petitioner removed an epidural catheter found on x-ray not to be in the epidural space. A replacement catheter was put in after two attempts. The replacement was the previously removed Davol silicone epidural catheter. Petitioner did so as a cost saving measure, and indicated that it was sterilized prior to reinsertion.

k. She returned on April 20, 1988 with complaints of marked headaches and pain in her legs. The catheter was checked and it aspirated CSF, indicating subarachnoid placement of the catheter. The catheter was removed and it was arranged for her to be admitted to Los Medanos Hospital. She was disoriented, nauseated and continued with severe headaches. Petitioner planned to schedule her for placement of a new epidural catheter under fluoroscopic control in the operating room once her other symptoms resolved. Further workup at the hospital revealed that J.W. had meningitis.

l. On May 8, 1988, J.W. was readmitted at Los Medanos Community Hospital for treatment of a reoccurrence of meningitis. At the time of her admission she had

a temperature greater than 101, a white blood cell count greater than 15,000, and was complaining of a stiff neck and headache. Petitioner had not done any procedures over the period between hospitalizations.

m. On June 1, 1988 at Los Medanos Community Hospital, Petitioner placed what was described during the administrative hearing as a percutaneous DuPen long term catheter as well as permanent subcutaneous port for J. W. The catheter was placed using fluoroscopy. Thereafter narcotic injections resumed. On June 13, J.W. complained that the catheter had stopped working. X-ray indicated that it had backed out of the epidural space and on July 5, 1988, the non-functioning catheter was removed. J. W. was started on Roxanol (oral morphine) and this medication was continued until a neurosurgeon could place a permanent indwelling catheter into the epidural space so that a pump could be used to instill narcotics.

n. In August 1988, J.W. had a permanent indwelling DuPen catheter and Davol subcutaneous injection port placed by a neurosurgeon at the county hospital. On August 23, J.W. returned to Petitioner and he provided her first injection into the newly installed port and provided her with a prescription for 25 gauge needles and Catapres, a drug that minimizes withdrawal symptoms. It was anticipated that she would have withdrawal symptoms after discontinuing oral narcotics. On August 28, 1988, J.W. reported that upon port injection, fluid was leaking out of the skin and that she was not obtaining good pain relief. Petitioner determined that fluid was leaking back along the catheter path and not staying in the epidural space.

o. Petitioner continued to see J.W. intermittently through January 25, 1991, when he was recalled to active duty. Petitioner was aware that she had been under reporting her use of medications and returning early for refills. There are no entries as to level of pain, activity level or side effects of the oral or injectable narcotics. Over this same period, J.W.'s mother had been diagnosed with cancer. Although Petitioner recommended placement of a pump, J.W. believed that a pump would necessitate a greater number of office visits and interfere with her remaining time with her mother.

p. On J.W.'s last visit on January 25, 1991, Petitioner persuaded her to go forward with placement of the pump, coverage for which had been previously authorized. In anticipation of that, he determined that a spinal block was necessary to assess dosage and to insure a good starting dose on her. A needle was placed subarachnoid in the L1-2 interspace and 1.0 mg of preservative free morphine was injected and determined to be a good starting dose for her. Details on her progress and treatment after January 1991 were not provided.

Accusation Allegations – Patient J.W.

At *Second Supp. Accusation Paragraphs 18A-E* – Respondent Medical Board alleged that Petitioner failed to perform a complete history and physical, did not initiate a treatment plan, and by not having same could not evaluate the patient at periodic intervals using the original history and physical as a baseline. Petitioner's history and physical examination were adequate for the intended purpose. (*See*, Exhibit FF) A treatment plan had been

formulated by Petitioner and J.W. was evaluated at periodic intervals. The ALJ found, and this Court agrees, that these Accusation allegations were not established.

At *Second Supp. Accusation Paragraph 18F* – Respondent Medical Board also alleged that Petitioner failed to use other medications or treatment modalities commonly used by pain management physicians.

It was noted in J.W.'s history (Exhibit FF) that she had already received a trial of medications and other treatment modalities. She had been to two other pain clinics and a neurologist, and she had also received psychological counseling. Other treatments recommended by Board expert, Dr. Levin were not on the market at that time (e.g. Capsaicin cream and selective serotonin reuptake inhibitors). Adjunctive therapies and medications were used by Petitioner. The ALJ found, and this Court agrees, that these allegations were not established.

At *Second Supp. Accusation Paragraph 18G* – Respondent Medical Board alleged that Petitioner incompetently, negligently or grossly negligently taught, encouraged and/or allowed J.W. to self-administer narcotics on an as needed basis, in the epidural and intrathecal catheters.

Allowing patients to self-inject narcotics via catheter epidurally has already been discussed herein and determined to be an extreme departure from the standard of care because of the risks associated with same. The same would also be true of catheters placed intrathecally (subarachnoid). Allowing patients to self-inject entails a high risk of infection in the epidural or intrathecal space, which can lead to permanent neurological damage or

death. The ALJ found that though the risk is well recognized and permitted for terminal cancer patients, it is not acceptable for non-cancer patients. This finding is supported by the weight of the evidence.

Petitioner's practice in allowing J.W. to self-inject narcotics was an extreme departure from the standard of care.

At *Second Supp. Accusation Paragraph 18H* – Respondent Medical Board also alleged that Petitioner incompetently, negligently or grossly negligently used deposteroids in the epidural space. This practice has already been discussed and is determined to be appropriate. It is also supported by medical literature submitted by Petitioner during the administrative hearing. It is acceptable to start a trial of epidural steroids and then abandon it if found as here to be ineffective. This allegation was not sustained.

At *Second Supp. Accusation Paragraph 18I* – Respondent Medical Board further alleged that Petitioner continued to repeat epidural or sympathetic nerve blocks in spite of the fact that J.W. exhibited no sustained response to same. It was argued that Petitioner should have known that if the injections were continued, each injection should have provided a more long lasting pain relief period and that if this did not occur the patient was not responding to the nerve blocks and they should have been abandoned, or a neurolytic block performed.

When J.W. was first seen she had a series of sympathetic blocks with some slight but apparent improvement. Her treatment was interrupted, and when she returned her pain was back at baseline. The series was repeated

until it became apparent that she was not going to respond with continued improvement. No further blocks were performed at that point and a neurolytic block was in fact recommended. (*See*, Exhibit 74 letter, p. 181.) J.W. was advised against the neurolytic block and she opted instead for a surgical sympathicectomy which was performed at Stanford University. For these reasons the Accusation allegations were not sustained.

At *Second Supp. Accusation Paragraph 18J* – Respondent Medical Board alleged that Petitioner prescribed numerous narcotics without evaluating the patient's response other than her subjective report of pain relief. It was argued that J.W. continued to rapidly escalate the dose and not keep detailed accounts of the medication that she was using. It was futher [sic] argued that without any objective improvement in her pain, and with the massive escalation in narcotic usage from Damason P to methadone and Roxanol, the continuing use of these narcotics was contraindicated.

Petitioner's notes on J.W. document functional improvement along with subjective reports of diminished pain. J. W. had pain in her knee to such an extent that she underwent a fusion operation. It is not clear what other objective measures of improvement were expected by Dr. Levin. J.W. was an intractable pain patient, and it was appropriate for Petitioner to be guided by her subjective reports of pain in managing her care and treatment.

At *Second Supp. Accusation Paragraph 18K* – Respondent Medical Board also alleged that Petitioner failed to investigate other specific treatments which may have been effective for J.W. In support, it was noted that once

intravenous Reserpine was determined to provide relief for up to one week, this procedure should have been repeated instead of epidural injections. The latter were providing shorter term relief and are considered to be more invasive and destructive therapies. Similarly, it was suggested that Petitioner should have tried spinal cord stimulation which is routinely used for reflex sympathetic dystrophy and is considered safer, more reliable, less costly and more effective than narcotics alone.

Petitioner testified that he did not pursue intravenous Reserpine therapy because it had been removed from the market at that time, and those who retained supplies in their office used same only sparingly. Petitioner did discuss spinal cord stimulation with her and after she left his care she actually went on trial stimulation therapy with poor results. In fact, a number of therapies including block therapy, neurolytic blocks, IV block, oral medications and stimulation had all been discussed with her by Petitioner. This Accusation allegation was not sustained.

At *Second Supp. Accusation Paragraph 18L* – Respondent Medical Board alleged that Petitioner incompetently, negligently or grossly negligently continued to repeatedly place temporary, as well as "permanent," epidural catheters, despite mechanical problems with the catheters and despite the fact that J.W. never had any evidence of sustained pain relief with the catheters. It was also alleged that he inserted the catheters in an non-sterile environment. The standard urged was that such be placed in surgery centers, and with standards in place for peer review or input.

There was no evidence that Petitioner placed the catheters in a non-sterile environment. It is clearly standard of care to do these procedures with sterile technique and in sterile surroundings. In the absence of any evidence that Petitioner did otherwise, this charge was not sustained. As far as the repeat placements, Petitioner noted that the reason the catheters needed to be repeatedly replaced is exactly because J.W. did not get sustained relief and because there were mechanical problems. Technical problems with the catheter's placement are no reason to discontinue that therapy. When properly placed, J.W. did obtain pain relief. This allegation was not sustained.

At *Second Supp. Accusation Paragraph 18M* – The matter of patient observation over 24 hours after epidural or intrathecal narcotic injection was discussed earlier. (*See*, PROPOSED DECISION, Finding 37.) Board expert, Dr. Levin acknowledged that Petitioner's practice is now considered appropriate.

At *Second Supp. Accusation Paragraph 18N* – Respondent Medical Board further alleged that on the final visit to Petitioner's office, he performed a spinal puncture on J.W. to inject morphine for evaluation of a starting dose for intrathecal narcotic infusion if a pump were placed, and that such injection had no clear indication and was therefore clearly excessive use of a diagnostic procedure.

Petitioner's medical objective was clear. He wanted to determine what starting dose would be appropriate. This was not merely a repeat of an earlier diagnostic procedure. As such, Petitioner's actions were reasonable

and not without medical indication. This allegation was not sustained.

At *Second Supp.* Accusation Paragraph 19 – The general allegations covering the period of J.W.'s treatment by Petitioner have already been covered herein. (*See*, PROPOSED DECISION, Findings 44 through 53.)

At *Second Supp. Accusation Paragraph 20* – Respondent medical Board alleged that on the visit when Petitioner administered an injection of morphine for evaluation of a starting dose for intrathecal narcotic infusion pump purposes, such constituted repeated acts of clearly excessive prescribing or use of treatments. By reason of the matters set forth above, this allegation was not sustained. (*See*, PROPOSED DECISION, Finding 53.)

VI. Patient A.C.

Seventh Cause For Disciplinary Action

Treatment History – Patient A.C.

a. Patient A.C. was first seen by Petitioner on November 30, 1987. The then 34 year old female complained of lower back pain, muscle spasm from shoulder blades to tailbone, and sporadic pain down through buttocks to lateral aspect of both thighs. The pain had persisted over three months from the time of her having an individual fall on her while she was in a squatting position. Her original diagnosis was lumbar strain and she was treated conservatively with rest and anti-inflammatories by another physician. Studies were negative for any acute processes or disc herniation, but degenerative changes (desiccation) were noted in the L1/2 and L5/S1

discs on a magnetic resonance imaging (MRI) scan. She was eventually referred to Petitioner by John Knight, M.D. for management of her muscle spasms and back pain. She was already on a regimen of Vicodin, 1-2 as needed for pain, Soma 1 every four hours and Feldene, 1 every morning.

b. Petitioner took a complete history and performed a physical examination. His diagnostic impression was that she had persistent ligamentous strain of the lumbar spine and possibly a problem in her sacroiliac joint contributing to her pain. Petitioner was told that she had previously received an epidural steroid injection, but not being satisfied that it was reported accurately to him, he determined to repeat the procedure himself. His plan was to do a differential epidural block with epidural steroids and probably narcotics to try to separate the back from the sacroiliac component; and depending upon the results, to refer her for manual therapy techniques. On this first visit an epidural injection was attempted with incremental 0.5% Lidocaine and 10 cc of 2% Nesacaine. A.C. reacted adversely with central nervous system (CNS) irritability with some twitching, hypertension and tachycardia. Petitioner noted no loss of consciousness, although A.C. believes that she passed out at the time. Petitioner suspected that the catheter had migrated into a blood vessel and planned to attempt the procedure again the following day.

c. On December 1, 1987, Petitioner repeated the differential epidural injection with incremental 0.5% Lidocaine. After about an hour and 200 mg total medication, she again had a CNS reaction with loss of consciousness. She was given two incremental 5 mg Valium injections IV

and her level of consciousness returned after 30 to 45 minutes. Petitioner completed the diagnostic block and determined that her continuing pain indicated that there was little or no sympathetic component. He subsequently injected DepoMedrol 80 mg, followed with 50 mg of Demerol. She experienced substantial pain relief and rested comfortably before leaving the office.

d. On December 3, 1987, Petitioner injected 5 mg of morphine via midlumbar epidural catheter. After a half hour, Petitioner injected another 5 mg of morphine, which provided her only partial pain relief. Believing that a small amount of Lidocaine would provide a little somatic block without any risk of repeating previous CNS symptoms, he injected 5 cc of 1% Lidocaine. She experienced involuntary twitching, but no loss or change of consciousness. She also developed marked itching and nausea which he related to the morphine injection, and for which she was given Narcan. Out of concern for her CNS reaction to epidural Nesacaine and Lidocaine, Petitioner referred A.C. to Robert Sternbach, M.D. for a neurology consultation. On January 22, 1988, Dr. Sternbach opined that it was unlikely that she would experience seizures or loss of motor control outside the epidural injections, notwithstanding his never having seen such a reaction in response to epidural anesthetics. Petitioner had already determined not to use any Lidocaine beyond that used to numb her for the injection itself and he planned to pursue other approaches including a weight loss program, spinal examination by his wife, Dr. Dahlis Day, and psychological counseling and/or hypnosis to help modify her perceptions of pain.

e. On December 10, 1987 Petitioner injected 10 mg of morphine via midlumbar epidural catheter with mild CNS effects for which she received 0.4 mg Narcan. On December 11 she was injected with a total of 20 mg morphine in the mid-upper lumbar epidural space, from which she reported good, long lasting relief.

f. On December 14, 1987 she received 10 mg morphine via catheter, which was then removed. A second 10 mg injection of 10 mg morphine followed through a single shot epidural technique. Some nausea was treated with a Narcan injection. Later that day, A.C. passed out in her office parking lot and was taken by strangers to John Muir Medical Center where she was hospitalized until December 16 for observation after excessive epidural morphine. Her admission symptoms included vomiting, rash, itching and bladder distention. Petitioner was not aware of this incident until after the fact.

g. On December 21, 1987 Petitioner removed the catheter and started A.C. on methadone 5 mg pills to see if she might receive better relief than from the Vicodin she was taking. He instructed her to titrate the dose with follow up visits; and to also begin a course of physical therapy, psychological counseling and techniques for modification of pain perception.

h. Between January and March 1988, A.C. tried various other methods of pain management including physical therapy, supportive counseling and self-hypnosis. In addition to taking methadone 10 mg every four hours for pain, she was also prescribed Vistaril for anxiety, Soma as a muscle relaxant and Deseryl 50 mg before sleeping as an anti-depressant medication. She reported getting very

poor relief with the methadone and other modalities and on April 5, 1988, indicated that she would like to try epidural morphine again.

i. Petitioner injected her on April 5, 1988 with 5 mg morphine via upper lumbar epidural catheter, followed by a second injection in that same amount. She had transient CNS symptoms with complaints of light-headedness and mild twitching. She reported that she was feeling better and getting good relief. Her 14 year old son was given some Narcan in a syringe in the event she had a problem. Petitioner merely made reference to her "attendant" being given the Narcan in a syringe.

j. On April 6, 1988, Petitioner injected her epidurally with 15 mg of morphine. He also taught her self-injection techniques, and continued such instruction over the next two office visits on April 7 and 8, when Petitioner had her draw up and administer morphine 15 mg to herself. He was satisfied that she demonstrated "very skilled technique" in drawing and giving morphine.

k. On April 11, 1988 A.C. reported 12-14 hours pain relief with self-injections of 15 mg morphine/day. However, she had developed a low grade fever, tenderness around the catheter site with a purulent discharge. Petitioner cleansed the site with peroxide and betadine, with the expectation that her son would continue this wash four times daily. He also prescribed the antibiotic Dicloxicillin 500 mg four times daily. He explained to her the concerns of further infection if not brought under control and noted that A.C. "was quite emphatic that she did not want the catheter removed, if at all possible."

l. On April 13, 1988 the tenderness around the catheter site had gone away. She had started giving herself a second injection at night, in a smaller amount, and reported receiving excellent relief. The progress report for that date does not indicate the amount of morphine she was self-injecting daily, and concludes by noting that Petitioner would follow up on an as needed basis.

m. On April 18, 1988 A.C. had a temperature of 100 degrees, with localized erythema/minimal tenderness, although Petitioner opined that it was not evidence of epidural infection. He planned to pull the catheter if it was a systemic infection, and his plan was to rule out same. On April 25, tenderness was again noted around the catheter site, her temperature was elevated, catheter injections were less effective and she complained of a headache. Respondent pulled the catheter and planned to use methadone during the interim until her temperature was back to normal. On April 27, a DuPen long term epidural catheter was placed in A.C. at approximately the L1-2 interspace.

n. The pertinent history of medical care and treatment between May 5 and September 6, 1988 is summarized in the Second Supplemental Accusation, paragraph 39 and is set forth below along with the minor changes made by the ALJ:

> **May 5, 1988** – The catheter was not working well and it was thought to be disconnected. X-ray with dye showed the catheter to be in the epidural space and the patient was injected with 15 mg of morphine.
>
> **May 12, 1988** – The patient complained of poor pain relief and nausea following larger doses,

without any notation of how much narcotic was being used or given. [Petitioner] assessed probable CNS effects of morphine sulfate and planned a Narcan trial but with no notation of how much would be given her.

May 20, 1988 – Injections do not give relief and fluid was observed coming out at the catheter site. The DuPen catheter was replaced in [Petitioner's] office.

May 27, 1988 – Visit for suture removal. Patient noted to have lost 15 pounds in one week. Chart notes that there would be a follow-up when A.C. has lost another 20 pounds.

June 8, 1988 – Catheter stopped working the day before with fluids coming out with injections. In his office, [Petitioner] removed the distal portion of the catheter and saved it. The same internal part of the catheter system was then reused and a new external part attached.

June 9, 1988 – A catheter connector failure was noted due to separation at the point where the internal and external catheters connect. The connection was repaired in [Petitioner's] office.

June 17, 1988 – Injectate completely leaking out of catheter site with poor pain relief. The patient felt like she was in withdrawal. The catheter was injected with 15 mg morphine while in the sitting position with no leakage.

July 25, 1988 – A.C. complained that the catheter had been very painful to inject. There was some erythema at the skin site. She continued to lose weight, approximately 35 pounds to date. She was started on a trial of antibiotics.

August 1, 1988 – There was leakage at the catheter site again. The catheter was revised, in office, again using the same internal part which was reinserted.

August 8, 1988 – The catheter continued to leak. It was injected with fluid and air. Fluid leaked back easily and air bubbles were felt distal to the catheter connection site, although X-ray showed the catheter to be in good position. [Petitioner] performed a replacement procedure of the epidural portion of the DuPen long term epidural catheter. He inserted a new 20 gauge nylon epidural catheter and secured same to the existing DuPen catheter.

August 15, 1988 – A.C. complained of pain upon injection but she was obtaining good pain relief. [Petitioner] injected a small amount of Depomedrol (20 mg) as trial for a possible non-specific inflammation. The injection was not for the purpose of trying to keep the catheter open.

August 24, 1988 – A.C. reported excellent results from the steroid injection of August 15, reducing pain with injection and lasting almost ten days. She requested a repeat injection and [Petitioner] injected DepoMedrol (20 mg).

September 6, 1988 – A.C. reported injections were becoming very painful for her again. She got good improvement in these symptoms for several weeks after injection of steroids and desired to repeat same. [Petitioner] injected DepoMedrol (20 mg). He noted that she continued to lose weight and that her problem may have been catheter migration which would have to be moved if she continued to have problems.

o. On September 9, 1988, A.C. was seen in the emergency room of Mt. Diablo Hospital with complaints of shortness of breath, coughing and wheezing following self-injection of morphine epidurally. She had a history of three to four weeks of mild episodes of "wheezing" after injection. She was given Alupent 0.3 cc and observed for an hour until her symptoms resolved. She was discharged with Benadryl 50 mg every six hours, and instructed to hold morphine injections and to follow up with Petitioner. Petitioner does not believe her described symptoms related at all to the morphine injections, but represented instead an anxiety reaction.

p. A.C. saw Petitioner on September 21, 1988 with complaints of pain upon injection, requiring her to inject herself over a two hour period. Petitioner found no evidence of infection. He injected her with 20 mg DepoMedrol.

q. On October 5, 1988, A.C. complained of mild difficulty breathing after her injections which was relieved with antihistamines. She also complained of painful injections. Petitioner injected Demerol epidurally, without recording the dosage. That evening she was seen in the emergency room of Los Medanos Community Hospital with complaints of severe back pain radiating to her left hip. A.C. reported a history of catheter migration and was given Valium intravenously, and injected with Lidocaine epidurally before being discharged home ambulatory. She saw Petitioner the following day.

r. On October 6, 1988, Petitioner determined that she likely had an epidural infection, but not an abscess. The epidural portion of the DuPen catheter was removed,

and the tip placed in a sterile container for gram stain and culture. She was then transported to Los Medanos Community Hospital where she was admitted with tenderness at the catheter site, an elevated white blood cell count (11,000 on admission), low grade temperature. The plan was to determine if the infection was superficial or parameningeal. Meningitis was ruled out. She was placed on antibiotic therapy and discharged on October 13 with a diagnosis of cellulitis at the site of the epidural catheter, chronic back pain and chronic narcotic use. Her discharge medications included methadone, 10 mg, three every four hours for pain.

s. On October 17, 1988, Petitioner saw A.C. and noted that her pain was under partial control with 30 mg methadone every four hours. He was concerned about further sedation and slow mentation as drug effects, and prescribed 5 mg amphetamine twice daily to minimize the side effects.

t. On November 2, 1988, Petitioner removed the external portion of the DuPen catheter. He noted that her pain relief was not very good with oral medications. He also discussed with her the possibility of surgery (lumbar spine fusion) with Dr. Barnes after further weight reduction on her part.

u. On November 29, 1988, A.C. reported that her methadone had not been working well for her over the preceding two weeks. He recommended that she increase her narcotic intake to 3-4 pills every four hours, and not the 2-3 that she had been taking.

v. On December 13, 1988, Petitioner refilled her medication prescriptions. Thereafter, over the next twelve

months, A.C. was seen at the Pain Relief Center in Walnut Creek principally by Petitioner's wife, Dahlis M. Day, M.D. She attempted with limited success to taper A.C. off methadone, starting with one less tablet per day per week.

Accusation Allegations – Patient A.C.

At *Second Supp. Accusation Paragraph 49A-C* – Respondent Medical Board alleged that Petitioner failed to record an adequate history or to perform a complete physical examination, did not initiate a treatment plan noting what objective features would be used to evaluate the success of the treatment, and therefore could not evaluate the patient at periodic intervals using the original history and physical as a baseline. As pointed out by the ALJ in his PROPOSED DECISION, Board medical expert John H. Eisele Jr., M.D., who had originally opined as such in his written report to the Board, retracted these criticisms after being shown pertinent medical records at hearing. These allegations were not sustained.

Petitioner's initial visit with A.C. is also criticized for his performing a differential epidural injection of steroids and local anesthetic to separate the back from the sacroiliac component of her pain. Dr. Eisele believes that the appropriate procedure would be to plan a sacroiliac joint injection to determine if that was the source of pain, or to perform an epidural steroid injection to assess its effect on her back. Petitioner opined that the sacroiliac joint is not an easy joint to identify and to inject, with a relatively low success rate. He also believes that it is possible to separate out the sympathetic and somatic components of

pain via his differential epidural injection. The ALJ found, and this Court agrees, it was not established that his approach was outside the standard of care.

Petitioner was also criticized for failing to aspirate before injecting epidural Lidocaine and Nesacaine. While it is true that his records do not reflect whether he aspirated, he testified at hearing that such is his usual habit and routine. He cannot be faulted for failing to record so basic a procedure. This also assumes that the catheter was placed in an epidural vein. Because her adverse reaction may have been psychologic, she was also referred to a neurologist for evaluation. The ALJ found, and this Court agrees, it was not established that Petitioner failed to aspirate before injecting epidural anesthetics.

At *Second Supp. Accusation Paragraph 49D* – Respondent Medical Board also alleged that Petitioner's injecting a narcotic (Demerol) into the epidural space at the same time as the steroids (DepoMedrol) only confused the pain assessment. The manner of Petitioner's use of differential epidural blocks has already been discussed. (*See*, PROPOSED DECISION, Finding 30.) The effects of Demerol would be known within six hours, and the effects of the steroid would be able to be assessed over 24 to 48 hours. It was a rational attempt to assess both drugs in an effort to find a long term solution to A.C.'s pain. The ALJ found, and this Court agrees, this allegation was not sustained.

At *Second Supp. Accusation Paragraph 49E* – Respondent Medical Board alleged that Petitioner failed to arrange for observation of A.C. over the 24 period [sic] after injection with epidural morphine. It is also alleged

that his subsequent injection of epidural Lidocaine in a patient known to have adverse reactions to epidural local anesthetics was strongly contraindicated. Petitioner's practice re observation of patients was discussed by the ALJ in his written decision. (*See,* PROPOSED DECISION, Findings 37 and 52.) Sending patients home after epidural narcotics is now accepted without the more prolonged observation period.

Petitioner opined that all documented instances of allergic reactions to Lidocaine are actually due to preservatives in multiple dose vials or to toxic reactions from IV injection or overdose. Petitioner testified that he injected Lidocaine that was preservative free. He took appropriate measures by referring her to a neurologist. He also involved her internist early on in his treatment. The ALJ found, and this Court agrees, that this allegation was not sustained.

At *Second Supp. Accusation Paragraph 49F* – Respondent Medical Board further alleged that Petitioner incompetently, negligently or grossly negligently allowed A.C. to self-administer morphine and, later, oral methadone, on an as needed basis. The issue of prescribing methadone on an as needed basis was found by the ALJ to be appropriate in certain cases where the outer parameters are defined (*See,* PROPOSED DECISION, Finding 25) and such is the case here. The issue of self-injection will be addressed later in this Statement of Decision.

Respondent Medical Board alleged further that Petitioner proceeded to prescribe powerful narcotics before ruling out other available treatment modalities first. Petitioner was aware that A.C. had already been to two other

physicians and had several trials of other therapies (*See*, PROPOSED DECISION, Finding 56a). It is appropriate for a pain treatment specialist to start a patient on narcotics if believed to be useful and attempts to treat the pain have been made by other physicians. The ALJ found, and this Court agrees, that this allegation was not sustained.

It was also alleged that A.C. had become addicted and that she was the one in control of the narcotics and that Petitioner had abdicated and lost total control of the situation to the point where he no longer knew how much morphine she was self-injecting. Board medical expert Dr. Eisele does not assert that A.C. became an addict. The ALJ found, and this Court agrees, that these allegations were not proven.

At *Second Supp. Accusation Paragraph 49G* – Respondent Medical Board also alleged that Petitioner incompetently, negligently or grossly negligently taught, encouraged and/or allowed A.C. to self-administer narcotics, on an as needed basis, in the epidural and intrathecal catheters.

The issue of self-injection has already been discussed and determined to be an extreme departure from the standard of care. (*See*, PROPOSED DECISION, Findings 17 and 46.) Twice A.C. was seen in the emergency room for adverse reactions to self-injected narcotics. Once she had to be hospitalized for an infection at the site of the catheter itself. Patient self-injection entails a high risk of infection in the epidural or intrathecal space. Trained medical personnel are in a better position to monitor such risks and to respond to any adverse patient reactions such as those experienced by A.C.

Second Supplemental Accusation Paragraphs 49H and 49J were dismissed by Respondent Medical Board during the hearing.

At *Second Supp. Accusation Paragraph 49I* – Respondent Medical Board alleged that Petitioner incompetently, negligently and/or grossly negligently performed procedures numerous times in a technically inadequate fashion, in an environment that was not aseptic and without use of a surgery center where these procedures are typically done.

It was argued that Petitioner should have status as a licensed surgery center before such procedures can be performed in his office. The ALJ found that there is no such legal requirement. It was also alleged that Petitioner should have implanted a narcotic infusion pump and spinal catheter which would have enabled him to exercise reasonable charge of the amount of narcotic to be administered and at the same time provide a totally enclosed (beneath the skin), aseptic system.

The matter of a sterile environment has already been discussed (*See*, PROPOSED DECISION, Finding 51.) Petitioner noted that most procedures are traditionally performed in surgery centers or hospitals only because most anesthesiologists are located there, and not in clinical settings such as his. While an infusion pump clearly has certain advantages, Petitioner believed his care for A.C. was to be transient and in anticipation of future discogram and surgery. Viewed in that context, an infusion pump was seen as unnecessarily expensive and something that would be difficult to have insurance carriers

underwrite. The ALJ found, and this Court agrees, that this allegation was not sustained.

At *Second Supp. Accusation Paragraph 49K* – Respondent Medical Board alleged that Petitioner continued to prescribe numerous narcotics without evaluating A.C.'s response other than her subjective report of pain relief and that without any objective improvement in her pain, the continuing use of these narcotics was contraindicated. A.C. assumed inappropriate control of her treatment regimen to the point that an epidural catheter was left in place despite a low grade fever and tenderness at the epidural catheter site.

It is appropriate to rely upon patient subjective reports of pain as a basis for treatment. The matter of leaving the epidural catheter in place was discussed with A.C. and she requested that it be left in place "if at all possible." This was not a refusal to have it removed, and was consistent with allowing patient participation in making treatment decisions. It was further alleged that Petitioner allowed A.C.'s minor son to be responsible for administering Narcan in a syringe to her if needed. The ALJ found, and this Court agrees, that this was an extreme departure from the standard of care. Teaching her minor son to assist her in injecting the narcotic antagonist narcan, if necessary, constituted gross negligence. These findings are supported by the weight of the evidence.

At *Second Supp. Accusation Paragraph 49L* – It was alleged that Petitioner caused A.C. to undergo, without medical indication or justification, numerous epidural

anesthetics with local anesthetic and narcotics. These procedures were argued to be without any diagnostic or therapeutic value and to constitute clearly excessive use of diagnostic and/or treatment procedures.

Petitioner avered [sic] that all blocks were performed in good faith and medically indicated for diagnostic or therapeutic purposes. This was supported by the medical record. The ALJ found, and this Court agrees, that the allegation was not sustained.

At *Second Supp. Accusation Paragraph 50* – The general allegations covering the period of A.C.'s treatment by Petitioner are covered herein. (*See*, PROPOSED DECISION, Findings 57 through 65.)

At *Second Supp. Accusation Paragraph 51* – It was finally alleged that the treatment provided to A.C. constitutes repeated acts of clearly excessive use of diagnostic treatment procedures (spinal anesthetics via epidural catheters) as determined by the standard of community of licensees. For reasons already discussed in herein, [sic] this allegation was not sustained. (*See*, PROPOSED DECISION, Finding 65.)

VII. Other Findings

This Court further finds, after applying the independent judgment test, that:

1. A principal controverted issue at trial was whether the Administrative Law Judge below applied the correct standard of proof, clear and convincing evidence to a reasonable certainty, in reaching his decision. The

Court finds that based on a review of the entire administrative record, the ALJ used the appropriate standard of proof at the administrative hearing. The clear and convincing evidence to a reasonable certainty standard of review found in *Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal. App. 3d 853 is a higher standard than the weight of the evidence standard to be employed in the instant case.

2. Another controverted issue before this Court is whether the Medical Board exceeded its jurisdiction in bringing its accusations against Petitioner. The Court finds that the Medical Board did not exceed its authority in filing its accustions against Petitioner and that Business and Professions Code § 2241.5, the so called "Intractable Pain Statute", was carefully considered by the ALJ and the expert witnesses who testified at the hearing. Section 2241.5 is not a bar to the Medical Board's action in this case. The ALJ pointed out in his PROPOSED DECISION, under the heading *"Overview of Pain Management Issues"*, a clear history of the evolution of the Board's *"Guidelines for Prescribing Controlled Substances for Chronic Pain"* leading to the Legislature's enactment of the "Intractable Pain Statute". (*See,* PROPOSED DECISION, pages 3 through 8.) The ALJ also considered the time period during which Petitioner treated each of the six patients stating in his PROPOSED DECISION, stating:

> "10. The time period over which [Petitioner] treated each patient is also important in the context of which practice standard to apply. **Throughout, Complainant's [MBC's] position has been to offer and to give [Petitioner] the**

> **benefit of the doubt with regard to the controlling standard of care.** The Intractable Pain Treatment Act and more recent Board pronouncements on prescribing controlled substances for pain postdate many of the allegations against Respondent. For these reasons **where current practice standards operate in [Petitioner's] favor, they will be applied instead of past standards.** The reverse is also true where it serves [Petitioner's] advantage." (Emphasis added. *See,* PROPOSED DECISION, p. 7, para. 10).

This Court also takes note that in addition to testifying based on their own independent review of the medical records in each case, each of the four experts called by Respondent Medical Board testified that he was familiar with Business and Professions Code § 2241.5, the so-called *"Intractable Pain Statue"*; The Medical Board's published *"Guidelines for Prescribing Controlled Substances for Intractable Pain"* and that in each instance, each expert gave petitioner the benefit of any doubt in any mitigatory change in the standard of practice. (See R.T., Vol. VII, p. 39, 1.1-25; pp. 189, 1.11- 191, 1.9; Vol. VIII, p. 20, 1.16-25, pp. 203, 1.7-204, 1.3; Vol. X, p. 203, 1.21-204, 1.16, pp. 205, 1.8- 206, 1.3, pp. 206, 1.16- 207, 1.10; Vol. IX, pp. 21, 1.20-22, 1.12, pp. 105, 1.6- 107, 1.5.)

3. Another issue raised by Petitioner before this Court is his allegation that he was entrapped by Respondent and also exposed to double jeopardy because the Navy also initiated proceeding against him, later dropped, based on his care and treatment of one of the same patients alleged in Respondent's action, patient M.G. This Court finds that Petitioner was neither

entrapped into practicing medicine as he did with the six patients in question nor was he placed in double jeopardy by the Board bringing its action against him concurrent with or after the Navy Proceedings against him. The specific facts of petitioner's care and treatment of the six patients, in some instances, began and ended even before § 2241.5 was enacted. Certainly he cannot claim an entrapment for this conduct. In addition, the ALJ gave petitioner every opportunity to prove to him that the Navy proceedings actually alleged malpractice by petitioner for the care and treatment of patient M.G. and that there were specific findings made relative to said patient ***and petitioner could not do so.*** (R.T., Vol. XXII, February 7, 1996, p. 12, 1.18-15, 1.22). Further, double jeopardy cannot apply here because petitioner has not been punished in a prior criminal prosecution and then subjected to an additional civil sanction to the extent that the second sanction may not fairly be characterized as remedial, but only as a deterrent or retribution. *Baldwin v. Department of Motor Vehicles* (1995) 36 Cal.App.4th 454, 42 Cal.Rptr.2d 422, at p. 428; quoting from *Department of Revenue of Montana v. Kurth Ranch* (1994) ___ U. S. ___ [114 S.Ct. 1937, at p. 1945]

4. This Court finds that Petitioner was not denied an opportunity to be represented by counsel. The decision not to hire counsel was Petitioner's alone and this Court does not find that Petitioner was denied a fair administrative hearing on this or any other basis.

5. This Court further finds that Respondent Medical Board's decision to revoke Petitioner's license; stay the revocation and place him on probation for five (5) years with terms and conditions was not an abuse of discretion.

It is well established that the propriety of a penalty imposed by an administrative agency is a matter vested in the discretion of the agency, and its decision may *not* be disturbed unless there is a **manifest abuse of discretion**. (*Nightingale v. State Personnel Board* (1972) 7 Cal.3d 507; *Harris v. Alcoholic Beverage, etc. Appeals Board* (1965) 62 Cal.2d 589; *Cadilla v. Board of Medical Examiners* (1972) 26 Cal.App.3d 961; *Blake v. State Personnel Board* (1972) 25 Cal.App.3d 541.) Petitioner has not established that Respondent Medical Board's decision represents a manifest abuse of discretion.

6. Another principal controverted issue at trail [sic] was whether the Administrative Law Judge below ruled correctly in finding that the Board was not barred from disciplining Petitioner because of the equitable defense of laches. The Court finds that based on a review of the entire administrative record, the ALJ was correct in ruling that Petitioner had failed to meet his burden of proof in regards to this alleged defense. The factual and legal basis for this determination is as follows:

A. As specifically found in ALJ Lew's decision, an administrative disciplinary action may be dismissed based on laches "where there has been an unreasonable delay between the discovery of the facts constituting the reason for the revocation and the commencement of the revocation proceedings, and where the licensee has been prejudiced by the delay." *Gates v. Department of Motor Vehicles* (1979) 94 Cal.App.2d 921, 925. However, in light of the finding in *Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, it is clear that, at least in Medical Board cases, the key to this equation is prejudice, not delay. After noting the statement of legislative intent for

the Medical Judicial Improvement Act (Stat. 1990, ch. 1597, § 39) and the legislature's "informed refusal in impose [sic] a statute of limitations on physician disciplinary proceedings," (38 Cal.App.4th at p. 815), the *Fahmy* court concluded; "It is apparent that the Legislature wishes to have the Medical Board protect California patients from physicians who are incapable of providing appropriate services in life or death situation, [sic] regardless of how long it takes the Medical Board to act." (38 Cal.App.4th at p. 816.) The court reversed both the trial court's finding that a three-year delay between the Board's learning of the facts leading to the disciplinary action and the filing of the accusation was unreasonable as a matter of law and its shifting of the burden of disproving prejudice to the Medical Board. Instead, the burden remained upon the physician to show "substantial evidence of prejudice." (38 Cal.App.4th at p. 815.)

B. Petitioner herein has failed, both at the administrative level as well as before this Court, to meet this burden. Petitioner presented little, if any, persuasive evidence in this regard. This Court also finds that Respondent Medical Board was not guilty of laches because it acted reasonably once it became aware of the facts giving rise to the various accusations against Petitioner and also because Petitioner was not prejudiced by any delay.

7. There was sufficient evidence presented by way of the Board's expert witnesses, one Board Certified Orthopedic Surgeon; one Board Certified Neurologist and two Board Certified Anesthesiolgists, that petitioner's care and treatment of the six patients alleged in the various accusations failed to fall within the prevailing standards of practice as found in the ALJ's PROPOSED

DECISION, adopted by Respondent Medical Board. See *Cooper v. Board of Medical Examiners* (1975) 49 Cal.App.3d 931, 941; *Gore v. Board of Medical Quality Assurance* (1980) 110 Cal App 3d 184, 198. Finally, in reviewing the findings of the Board, it should be noted that the *burden* rests on the complaining party to convince the court that the Board's decision is contrary to the weight of the evidence. (*Drummey v. State Bd. of Funeral Directors,* (1939) 13 Cal.2d 75, at 84-85). It is established that the "weight of the evidence" is synonymous with "a preponderance of the evidence" (*Chamberlain v. Ventura Co. Civil Service Comm'n* (1977) 69 Cal.App.3d 362). Petitioner herein has failed to meet his burden of proving that Respondent's decision against him is contrary to the weight of the evidence. A further basis for the Court's determination is that there was insufficient evidence to support Petitioner's proffered affirmative defenses at the administrative hearing and other contentions before this Court. The Petitioner herein had the burden of persuading this Court by a preponderance that the Board's decision was invalid and he also had the accompanying burden of producing evidence. (Evidence Code §§ 550 and 606; *Campbell v. Board of Dental Examiners* (1971) 17 Cal.App.3d 872; *Chamberlain v. Ventura County Civil Service Commission, supra,* 69 Cal.App.3d at p. 371). Petitioner failed to meet this burden of proof before the Court.

8. As to Petitioner's contention that the failure by Navy personnel to accept and comply with subpoenas as witnesses, served on them by Petitioner, to appear at the administrative hearing below, this argument is entirely disingenuous since Respondent had no control over Navy

personnel and the duty, if any, to seek to enforce subpoenas was entirely Petitioner's. The record is devoid of what, if any efforts Petitioner made to attempt to locate these former Navy employees or that they had relevant or percipient knowledge regarding the issues before the ALJ.

9. The Court also finds that no prosecutorial or judicial misconduct occurred. The ALJ did not receive evidence outside of the record. Although Petitioner hereby raises a defense of discriminatory enforcement, alleging "the Board has a hidden agenda" in prosecuting him, no evidence was presented to show that either the Board or the Office of the Attorney General had singled him out for prosecution on some invidious basis or that he would not have been prosecuted but for such alleged discrimination. (See *Murgia v. Municipal Court* (1975) 15 Cal.3d 286; *People v. Smith* (1984) 155 Cal.App.3d 1103.) Here, Petitioner makes only a claim without producing any competent evidence of discrimination. Therefore, Petitioner has failed to carry his burden of proof.

10. Petitioner also argues that Respondent Medical Board, through the ALJ, did not adequately consider and appraise the record evidence. He argues that it should have disclosed in its findings its *reasoning* regarding the evidence in mitigation; i.e., that he had no history of prior unprofessional conduct and was practicing medicine, pain management, in a state of evolution that "safe" practioners feared to practice. This proposition is not supported by either the facts or case law. Findings on mitigation in administrative proceedings are not required, absent a statute to that effect, and it will be

presumed by a reviewing court that all mitigating evidence presented at the hearing was considered. (*Otash v. Bureau of Private Investigators* (1964) 230 Cal.App.2d 568, 574.)

11. Another principal controverted issue in the Petition was whether the Board proceeded in the manner required by law thereby possibly denying Petitioner a fair administrative hearing on this basis. The Court finds that based on a review of the entire administrative record, Petitioner was not denied a fair administrative hearing. The factual and legal basis for this determination is as follows:

A. The decision is extremely detailed and well reasoned. Over the course of 22 days of hearing, ALJ Lew was able to carefully gauge the expertise, credibility and demeanor of the witnesses who testified before him, including Petitioner; the five patients who appeared at the hearing as well as numerous expert witnesses called by both parties. ALJ Lew then proceeded to make specific written findings thereon which clearly set forth for all interested parties what his thought and deliberative process was between the raw evidence, his findings of fact, determination of issues and decision as to ultimate disposition. ALJ Lew demonstrated in his written decision an extensive knowledge of the law, the medical issues involved and his duties pursuant to the law.

B. Petitioner represented himself at the administrative hearing, and from the record, the ALJ provided him with much leeway in his case presentation as well as in his cross-examination of all of the Board's witnesses. Petitioner was able to examine and raise objections to the

documentary evidence introduced into the record, to call numerous expert witnesses, all in addition to various members of Petitioner's former office staff as well as himself to testify.

C. Evidence Code section 664 indicates that a state agency is presumed to have regularly performed its duties. This shifts the burden to Petitioner to show that such a duty has not been performed. Through sheer innuendo and no supporting evidence, Petitioner has presented no evidence to support any such allegation.

WHEREBY JUDGEMENT IS HEREBY ORDERED to be entered as follows:

1. The Petition of a Peremptory Writ of Mandate is DENIED;

2. The Temporary Stay entered into by the parties, via stipulation, and adopted by the Court in this action on November 14, 1996, is DISCHARGED; and

3. Petitioner take nothing by this action.

DATED: 6/16/97, 1997.

/s/ William Cahill
THE HONORABLE
WILLIAM CAHILL
Judge of the Superior Court

DANIEL E. LUNGREN, Attorney General
of the State of California
ALFREDO TERRAZAS, State Bar No. 78403
Deputy Attorney General
Deputy Attorney General
2101 Webster Street, 12th Floor
Oakland, California 94612-3049
Telephone: (510) 286-3795
Fax No.: (510) 286-4020

Attorneys for Respondent
Medical Board of California

IN THE SUPERIOR COURT OF THE STATE OF CALIFORNIA FOR THE CITY AND COUNTY OF SAN FRANCISCO

FRANKLIN JEROME DAY, M.D. Petitioner, vs. **DIVISION OF MEDICAL QUALITY OF THE MEDICAL BOARD OF CALIFORNIA,** Respondent.	**NO. 982562** **ORDER DENYING PEREMPTORY WRIT OF MANDATE** **(Code of Civil Procedure § 1094.5(h)** **DATE: Jan. 31, 1997** **TIME: 9:30 a.m.** **DEPT: 8, Judge Cahill**

(Filed Feb. 11, 1997)

This matter was scheduled and heard before this Court on January 31, 1997. Alfredo Terrazas, Deputy Attorney General, appeared as counsel for respondent the Division of Medical Quality of the Medical Board of

California. The appearance on behalf of petitioner was made by Franklin Jerome Day, M.D., *in propria persona*, and oral argument was held.

The record of the administrative proceedings having been received into evidence and examined by the court, and additional oral and written arguments and legal briefings having been submitted by the parties in their respective written moving and responsive pleadings;

THE COURT FINDS, after it has applied the Independent Judgment Test, that:

(1) The evidence presented at the administrative proceeding before the Administrative Law Judge below was sufficient to support the findings made by the Administrative Law Judge. The findings of fact and determination of issues made by Administrative Law Judge (ALJ) Jonathan Lew at the administrative level below represent an extremely careful, thorough and thoughtful recitation of the evidence in regards to the care and treatment rendered by petitioner to each of the six patients identified in the various Accusations filed by respondent, the Medical Board of California. The facts regarding patients A.C. and B.C. alone are sufficient for the disciplinary order recommended by ALJ Lew and adopted by respondent.

(2) The findings support the proposed decision of the Administrative Law Judge which was adopted, in its entirety, by the Division of Medical Quality of the Medical Board of California. Petitioner's medical license was disciplined by an order of revocation; which was stayed, and he was placed on a five year probation with specific

terms and conditions. The terms and conditions are themselves reasonable, including the requirements that he take and pass and [sic] oral clinical examination as a condition precedent to continued practice; that he increase his annual continuing Medical Education hours as ordered and that he nominate and secure a qualified physician monitor for his practice.

(3) The Division of Medical Quality of the Medical Board of California did not abuse its discretion in adopting the Administrative Law Judge's decision as its own. Respondent clearly had jurisdiction over petitioner's acts or omissions as a physician. In the case of the one patient, M.G., who was treated by petitioner at Oak Knoll Naval Hospital, petitioner was practicing as a private practice physician away from the Naval Hospital at two separate facilities in San Leandro and Walnut Creek, California during the same relevant period of time. The evidence also shows that he had independently placed himself within the jurisdiction of respondent when he sought and secured California licensure as a physician when, had he been practicing solely and exclusively as an employee of the navy and provided medical services exclusively on a federal facility wholly supported and maintained by the U.S. Government, respondent could not have compelled him to secure such licensure. Finally, Business and Professions Code § 2305 clearly allows respondent to take action against one of its licensees where, as here, Oak Knoll Naval Hospital moved to restrict the authority of petitioner to practice medicine. Petitioner is only licensed as a physician in California and federal statutes clearly require that his status as a health care professional in the Naval armed services, specifically requires and depends

on him having a current license to provide such care by grant of permission from an official agency of, among others, a state. (See 10 U.S.C.A § 1094, (a), (1) and (d), (1), (A).)

(4) The Medical Board of California proceeded in the manner prescribed by law. Petitioner was originally represented by counsel following the filing of the initial accusations made by respondent. The subsequent loss of counsel by petitioner was not the fault of respondent. Petitioner had ample notice of the hearing dates for the administrative hearing below and, in one instance, the hearing was continued at the request of petitioner and his counsel. The denial of a second request for a continuance by petitioner, in pro per, which was originally made in a letter from petitioner to ALJ Lew dated October 23, 1995 (See Declaration of Alfredo Terrazas in Support of Answer, Exhibit E), denied by ALJ Lew in his letter of November 1, 1995 (See Declaration of Alfredo Terrazas in Support of Answer, Exhibit G) was proper. The request for continuance, renewed by petitioner at the second Pre-Hearing Conference before ALJ Lew on November 17, 1995 was likewise proper. (See Declaration of Alfredo Terrazas in Support of Answer, Exhibit H). Petitioner knew as early as shortly after September 21, 1995 that his counsel had withdrawn from the case and he was under obligation to report this within 10 days if he wished to use it as the basis for a second request for a continuance. (See Declaration of Alfredo Terrazas in Support of Answer, Exhibit F and Government Code § 11505 (b).)

(5) The Administrative Law Judge below correctly applied the "clear and convincing evidence to a reasonable certainty" standard of review in weighing the

evidence placed before him at the administrative hearing. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal. App. 3d 853; Evidence Code section 664). ALJ Lew stated the burden of proof utilized by him by referring to it in his proposed Decision on page 17, paragraph 20, where he stated in regards to respondent's evidence "It has failed to present clear and convincing evidence to a reasonable certainty that [Petitioner's] actions in treating patient M.O., though unusually aggressive, were in violation of the Code sections cited". Even assuming arguendo that the incorrect burden of proof was applied by ALJ Lew, however, it would be, and therefore has been, cured by this Court's application of the weight of the evidence test upon its independent review of the administrative record.

(6) Petitioner was not denied an opportunity to be represented by counsel by any actions of respondent at the administrative hearing below. A reading of the letter from petitioner to ALJ Lew; the response letter from ALJ Lew to petitioner; the letter dated October 18, 1995 to petitioner from the law firm that had been representing him and ALJ Lew's second Pre-Hearing Conference Order of November 17, 1995 dated November 21, 1995 makes it abundantly clear that petitioner alone was responsible for the fact that he was not represented by counsel at the administrative hearing. (See Declaration of Alfredo Terrazas in Support of Answer, Exhibits E, F, G and H.) When ALJ Lew granted petitioner's earlier request for a continuance during the first Pre-Hearing Conference of May 16, 1995, (petitioner was designated "respondent" in the proceeding below), the new hearing dates were stipulated to by the parties, thus petitioner

had over six months notice of the actual hearing dates. (See Declaration of Alfredo Terrazas in Support of Answer, Exhibit D.)

(7) The Court has also reviewed and considered all of petitioner's remaining legal and factual arguments not specifically discussed previously in this order and finds that they have no merit.

WHEREFORE, IT IS HEREBY ORDERED, ADJUDGED AND DECREED THAT:

1. The petition filed in this action for a Peremptory Writ of Mandate is denied;

2. The stay of the final decision by respondent, stipulated to by the parties pending the hearing and order in this matter, is discharged;

3. Petitioner's request for costs and attorney's fees are denied;

4. The parties shall each bear their own costs in this litigation; and

5. Respondent is ordered to prepare a Statement of Decision in conformity with this order.

DATED: 2/10/97, 1997.

/s/ William Cahill
THE HONORABLE
WILLIAM CAHILL
Judge of the Superior Court

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DIVISION OF MEDICAL QUALITY
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	Case No. D-5613
FRANKLIN JEROME DAY, M.D. 310 North Civic Drive, #510 Walnut Creek, CA 94596 Certificate No. G-39260	)	OAH No. N 9402130
Respondent.	)	

DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Medical Board of California as its Decision in the above-entitled matter.

This Decision shall become effective on September 9, 1996.

IT IS SO ORDERED August 9, 1996.

/s/ Ira Lubell M.D.
Ira Lubell, M.D.
Chair, Panel A
Division of Medical Quality

OAH 15 (Rev. 6/84)

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DIVISION OF MEDICAL QUALITY
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	
FRANKLIN JEROME DAY, M.D. 310 North Civic Drive, #510 Walnut Creek, CA 94596 Certificate No. G-39260	Case No. D-5613
Respondent.	OAH No. N 9402130

PROPOSED DECISION

This matter was heard before Jonathan Lew, Administrative Law Judge, State of California, Office of Administrative Hearings in Oakland, California. The hearing commenced January 2, 1996 and continued for twenty-two days through February 7, 1996.

Complainant was represented by Alfredo Terrazas, Deputy Attorney General.

Respondent Franklin Jerome Day, M.D. was present and represented himself.

Submission of the matter was deferred to provide the parties an opportunity to file closing briefs. Agreement was reached to an extended briefing schedule, which was twice modified per request by each party. Complainant's Opening Final Argument and Post Hearing Brief was received April 12, 1996, and marked as Exhibit 109 for identification. Respondent's Final Argument and Brief was received May 24, 1996, and marked as Exhibit KK for

identification. Complainant's Final Argument and Post Hearing Brief was received on June 18, 1996, and marked as Exhibit 110 for identification. The matter was thereafter submitted for decision on June 18, 1996.

FINDINGS OF FACT

Respondent's License History and Background

1. Complainant Dixon Arnett, Executive Director of the Medical Board of California (Board) made the charges and allegations set forth in the Accusation (2/2/94) and First Supplemental Accusation (2/16/95) solely in his official capacity. Complainant Doug Laue as the Acting Executive Director of the Board made the additional charges and allegations in the Second Supplemental Accusation (10/13/95) solely in his official capacity.

2. *License History*: At all times pertinent Franklin Jerome Day, M.D. (Respondent) has held physician and surgeon certificate No. G 39260, which was issued to him by the Board on May 18, 1979. Said certificate was in good standing as of the November 16, 1993 license verification (Exhibit 2), and had an expiration date of March 31, 1995. No prior disciplinary action has been taken against the certificate. Respondent was also a supervisor of a physician assistant, however his supervisor physician assistant License No. SA 14333 is in a delinquent status, the expiration date being May 31, 1988.

3. *Medical Background*: Respondent is a United States Naval Academy graduate with a degree in Applied Science (1966). After serving as an Engineering and Line Officer on board nuclear submarines, he attended and received his medical degree from the University of

Hawaii (1976), and continued his internship program with the National Naval Medical Center, Bethesda, Maryland. He then did a residency in anesthesiology first at the Naval Regional Medical Center, San Diego (1978-79), and then through the Naval Hospital, Oakland (1981-83).

From January 1984 through December 1984 he was head of the Anesthesiology Division, Department of Surgery, Naval Hospital, Corpus Christi, Texas. From December 1984 through December 1990, he worked as an anesthesiologist with Los Medanos Hospital, Pittsburg, California. Over that same period, he founded and was medical director of the Pain Relief Center, with offices in Walnut Creek and San Leandro, California. This practice continued through March 1994, after which date it was closed due to Navy obligations.

Between December 1990 and December 1994, Respondent served as Staff Anesthesiologist at the Naval Hospital in Oakland. He was recalled to active duty as part of Operation Desert Shield/Storm in December 1990, and was made Director of the Anesthesiology Pain Clinic and Assistant Department Head. In 1993 the residency program was integrated with the University of California San Francisco School of Medicine anesthesiology residency program, and Respondent was designated Assistant Clinical Professor of Anesthesia – UCSF. Professional certifications held by Respondent include status as Diplomate, American Board of Anesthesiology #22749; Diplomate, American Board of Pain Medicine; Diplomate, American Academy of Pain Management and Diplomate, National Board of Medical Examiners.

Respondent now holds or has held membership in the American Academy of Pain Medicine, American Academy of Pain Management, Northern California Anesthesia Society and the Bay Area Anesthesiologist Society.

Overview of Pain Management Issues

4. This case looks to a broad range of issues concerning Respondent's management and care of chronic, nonmalignant pain patients. The issues relate both to the governing standard of care as well as to the more specific factual allegations regarding his treatment of six pain patients. With regard to the former, a history and overview of Board policy guidelines for prescribing controlled substances for intractable pain will be useful in defining the more general standard of care to be applied. And because there are as many as ten medical practice issues involving multiple patients, such issues will also be defined initially. This will be followed by individual case histories and findings of fact that relate specifically to Accusation allegations. It will include a more detailed analysis of whether Respondent's specific medical practices in treating each of these six patients departed from or fell within the applicable standard of care.

5. As recently as October 1994, the Medical Board of California strongly urged physicians to view effective pain management as a high priority in all patients.[1] In its Action Report sent to California physicians the Board

---

[1] See Medical Board of California Action Report, October 1994, p. 8. (Exhibit 99).

recognized that drugs, in particular the opioid analgesics, are considered the cornerstone of treatment for pain associated with trauma, surgery, medical procedures and cancer. The Board recognized that the "prescribing of opioid analgesics for other patients with intractable non-cancer pain may also be beneficial, especially when efforts to remove the cause of pain or to treat it with other modalities have been unsuccessful." Yet, because inappropriate prescribing of controlled substances including the opioids may also lead to drug abuse or addiction, the Board also recognized that some physicians do not properly treat pain out of fear of discipline by the Board. To better clarify its position the Board has repeatedly publicized its guidelines on prescribing controlled substances for intractable pain, as well as California's Intractable Pain Treatment Act, enacted in 1990, and which provides in part:

> "(c) No physician and surgeon shall be subject to disciplinary action by the board for prescribing or administering controlled substances in the course of treatment of a person for intractable pain."

(See Business and Professions Code section 2241.5.)

6. In its July 1994 Action Report (Exhibit R), the Medical Board issued a statement specifically addressing concerns about Board discipline of physicians in connection with their prescribing controlled substances:

> "Concerns about regulatory scrutiny should not make physicians who follow appropriate guidelines reluctant to prescribe or administer controlled substances, including Schedule II drugs, for patients with a legitimate medical need for

> them. A physician is not subject to Board action when prescribing in the regular course of his or her profession to one under a physician's treatment for a pathology or condition and where the prescription is issued after a good faith examination and where there is medical indication for the drug. *Good faith prescribing requires an equally good faith history, physical examination and documentation.* . . .
>
> The Board will judge the validity of prescribing based on the physician's diagnosis and treatment of the patient and whether the drugs prescribed by the physician are appropriate for that condition, and *will not act on the basis of predetermined numerical limits on dosages or length of drug therapy.*" (Emphasis added.)

7. In that same July 1994 Action Report the Board was careful to define the term addiction. Because Respondent is charged with causing certain patients to become "addicted" to controlled substances, and also with furnishing controlled substances to known "addicts" without legitimate medical purpose, the term "addiction" must have precise meaning. The Board's definition of addiction corresponds to that of most testifying expert medical witnesses and follows:

> "The Board believes that addiction should be placed into proper perspective. Physical dependence and tolerance are normal physiologic consequences of extended opioid therapy and are not the same as addiction. *Addiction is a behavioral syndrome characterized by psychological dependence and aberrant drug-related behaviors.* Addicts compulsively use drugs for non-medical purposes despite harmful effects; a person who is addicted may also be physically dependent or

> tolerant. Patients with chronic pain should not be considered addicts or habitues merely because they are being treated with opioids." (Emphasis added.)

The definition of addiction emphasizes compulsive drug use and drug seeking behavior, combined with a high tendency to relapse after withdrawal sets in. Because the psychological element is critical in determining whether a patient has become "addicted," the physician is responsible for providing extra care and monitoring of such patients, as well as consultation with medical specialists whose expertise is substance abuse or pain management.

8. Prescriptions cannot be made for the purpose of providing the patient with "controlled substances, sufficient to keep him or her comfortable by maintaining customary use." (Health and Safety Code section 11153(a).) However, controlled substances may be prescribed when the physician in good faith believes that a patient suffering from disease, ailment, injury or infirmities attendant upon old age, requires such treatment; and then *only in such quantity and for such length of time as are reasonably necessary.*" (Health and Safety Code section 11210)

9. As early as 1985, the California Medical Association and the Board of Medical Quality Assurance (BMQA, the equivalent of today's Medical Board) produced Guidelines for Prescribing Controlled Substances for Chronic Conditions. While not definitive of the controlling standard of care in this case it summarizes the Medical Board's thinking over much of the relevant period that Respondent's conduct is being challenged. It also reflects medical practice standards as expressed more

generally by testifying medical expert witnesses. The 1985 Guidelines as summarized in a Board 1991 Action Report were to be used in context of a comprehensive treatment plan and follow:

> **"1. History and Medical Examination.**
>
> A diagnostic examination and an adequate medical history must be performed to establish a diagnosis and treatment plan.
>
> **2. Diagnosis/Medical Indication.**
>
> A working diagnosis must be delineated, which includes the presence of a recognized medical indication for the use of any treatment or medication.
>
> **3. Written Treatment Plan With Recorded Measurable Objectives.**
>
> The plan should have clearly stated, measurable objectives and give indication of further planned diagnostic evaluation and alternative treatments.
>
> Judicious use of treatment and medication prevents overuse and minimizes iatrogenic [physician induced] addiction problems.
>
> **4. Informed Consent.**
>
> Discussion of risks and benefits should be recorded in the patient record.
>
> **5. Periodic Reviews and Modifications Indicated.**
>
> At these times, the physician should consider the development of any new information. It is at this time the physician should consider

and document appropriateness of continued treatment or the trial of other modalities if the patient has not improved. It is also mandatory to diligently reassess the patient to exclude treatable causes of the symptoms.

6. Consultation.

Today there is an abundance of solid expertise. As the patient's primary advocate, the doctor should be knowledgeable and competent in referring them to the appropriate expert. Consultation reports should become part of the patient's medical record.

7. Records.

The physician should keep accurate and complete records documenting the dates and clinical findings for all evaluations, consultations, treatments, medications and patient instructions. It is particularly important for that small subset of patients who are diagnosed as having chronic intractable pain."

Complainant offers the entire 1985 joint CMA and BMQA Guidelines by way of official notice under Government Code section 11515, as a restatement to all licensed physicians of what the standard of care already was. Official notice is so taken of these Board guidelines, but not as a restatement of the standard of care. The guidelines are useful, but not definitive. While generally probative of the governing standard of care, even Board medical expert witnesses differed, albeit not significantly, in their recitation of the controlling general standards of practice for prescribing controlled substances. For example, Board

expert Dr. John Eisele suggests that the governing standards that he articulated essentially reflected good medical practice and were "not in writing." He was apparently unaware of the 1985 Board guidelines.

Both parties have correctly noted that the standard of care against which acts are to be measured "is a matter peculiarly within the knowledge of experts; it presents the basic issue in a [malpractice] action and can only be proved by their testimony." (*Sinz v. Owens* (1949) 33 Cal.2d 749, 753.) The 1985 Guidelines should therefore be considered along with medical expert testimony in determining whether Respondent's practice of prescribing controlled substances for pain in each case were within the standard of care.

10. The time period over which Respondent treated each patient is also important in the context of which practice standard to apply. Throughout, Complainant's position has been to offer and to give Respondent the benefit of the doubt with regard to the controlling standard of care. The Intractable Pain Treatment Act and more recent Board pronouncements on prescribing controlled substances for pain postdate many of the allegations against Respondent. For these reasons where current practice standards operate in Respondent's favor, they will be applied instead of past standards. The reverse is also true where it serves Respondent's advantage.

11. Accusation allegations relate to Respondent's care and management of six patients with complaints of

chronic non-malignant pain. Each patient's relevant medical history and treatment by Respondent will be summarized, followed by a discussion of the specific allegations referenced in the seven causes for disciplinary action. where common practice issues arise among different patients, cross references to earlier discussion of those same issues will be made.

12. The following practice issues raised by Complainant (Exhibit 109, p.8) will be addressed in evaluating whether Respondent's management and treatment of pain for these patients was appropriate:

- The manner and methods used by Respondent in evaluating (including patient histories and adequate initial physical examinations) which treatments to employ, when and why;
- Whether Respondent engaged in a weighing process assessing known and foreseeable risks associated with treatment methods versus the anticipated medical benefits, both at the inception of treatment a [sic] well as during relevant re-evaluation periods;
- Whether Respondent fully informed his patients of the potential complications and side effects of treatment methods so as to obtain fully informed consent for initiating and continuing treatment;
- Routes of delivery [temporary and permanent catheters and the points of insertion of said catheters] of specific drugs used by Respondent;
- Allowing patients to self-inject opioids and other medications and to maintain the sterility associated with the use of various catheters;

- The combination of various treatment modalities [combination diagnostic blocks] without first adequately assessing the relative usefulness or uselessness of treatment;
- The relative onset/half-life of methadone;
- The length of time and the manner in which drugs were to be used, i.e., whether on a time based administration or on an as needed (prn) basis;
- The propriety of the use of drugs for individuals with a high potential for drug abuse, either currently or in the past; and
- The failure to recognize and act upon complications resulting from his treatments, including dangerous infections, side effects of long term steroid use and the development of an addiction to narcotics by his patients.

First and Second Causes for Disciplinary Action

13. Treatment History – Patient M.O.

a. Patient M.O. was first seen by Respondent on January 23, 1987. She was 35 years old at the time, and presented with chief complaints of neck, back, and left arm pain. Her symptoms related back to an industrial accident occurring on April 9, 1985. She had been seen by several other doctors before being referred at her request by Marvin Zwerin, M.D. to Respondent for management of her pain.

b. M.O. was a former body builder and aerobics instructor. While working in April 1985 as a freight cashier for Hanjin Container, she was startled by noise from a robbery in progress, and twisted her neck. Within a day

she developed severe pain in her neck about the occipital area, and pain in her left upper arm, left shoulder and the upper left hand quadrant of her back. Following initial treatment by a chiropractor, she underwent a neurological evaluation. Magnetic resonance imaging (MRI) scans indicated a herniated disc at the C5-6 level, and eventually she underwent a cervical discectomy at this level with an anterior fusion in September 1985. Surgery was followed by six weeks bed rest. There was no significant improvement in her pain.

c. Prior to seeing Respondent, M.O. had received trials of treatment of physical therapy, acupuncture, TENS, traction, ice, spray and stretch, massage with ultrasound, and trigger point injections with local anesthetic and cortisone; all with little effect. Medications that had been tried included Vicodin, Talecin, Xanax, Parafon Forte, Naprosyn and Elavil.

d. On her first visit with Respondent, M.O. completed a fairly comprehensive personal medical history. It included detail on medications, past treatments/therapies, location and degree of pain and other relevant personal/medical information. There is also a two page record of a physical examination performed that day, again detailing her complaints of pain, symptoms and pertinent treatment history. (Exhibit JJ) A plan of treatment is not part of the initial history and physical examination. However, progress reports for that visit indicate that Respondent felt that she had a sympathetic dystrophy in addition to her chronic cervical strain. After performing a differential thoracic epidural block (incremental injections of .5% lidocaine) to confirm the sympathetic component of her pain, his progress notes record a

plan to have her return in three days for repeat sympathetic blocks, as necessary. He also gave her an epidural injection of 80 mg Depo-Medrol, and planned to followup in one week for repeat epidural steroids.

e. By letter dated February 11, to referring physician Dr. Zwerin, Respondent provides his initial diagnostic impressions and treatment plans for M.O. He opined that M.O. was suffering from a combination of chronic cervical nerve irritation and a reflex sympathetic dystrophy, confirmed by the differential epidural block results. The cervical epidural steroid injections were for the suspected nerve root inflammation and irritation. Respondent notes that with an aggressive series of epidural steroid injections, she started getting substantial periods of improvement in her pain. He also performed trigger point injections in the trapezius with local anesthetic. He noted on February 11:

> "[M.O's] problems have been longstanding and complex and I'm not yet sure how long she will require treatment here. She does seem to be responding to our therapy, although not as rapidly as I would have anticipated. Hopefully, physical therapy combined with my treatments will allow her a chance for full rehabilitation. I will continue to aggressively pursue therapies." (Exhibit 8, 2/11/87 Letter to Dr. Zwerin)

f. Respondent did engage in aggressive treatment of M.O. Between January 23 and October 27, 1987, there were approximately 56 visits. Within a week of starting treatment with Respondent, M.O. was prescribed the more potent methadone, and taken off Vicodin. Over the

treatment period he performed 14 epidural local anesthetic or epidural differential local anesthetic blocks, 24 epidural steroid injections, 9 stellate ganglion blocks with local anesthetic, 19 sets of trigger point injections and 1 Bier block.

g. On June 22, 1987, Respondent noted that he would begin instructing M.O. on self-injection of Duramorph (morphine) epidurally and would give her a ten day supply of same to see if he could achieve "long lasting relief." Thereafter, M.O. continued self-injection of morphine daily until her September hospitalization. In answer to her queries, Respondent told M.O. that she would not become addicted to the morphine because it was being injected directly into the epidural wall of her spine. M.O. would receive temporary relief from her pain until the medications would wear off. Respondent told her that if she could continue with the treatment for six months to a year, that her pain condition would be better.

h. Respondent also referred her for a functional capacity assessment performed at Wilson's Physical Therapy. In view of her emotional liability and slow response to therapy, Respondent referred her to a psychiatrist to help her deal with the emotional problems associated with her chronic pain. A psychological consultation was performed by Douglas Korpi, Ph.D. on July 30, 1987. Dr. Korpi opined that she had an adjustment disorder with mixed emotional features, and that psychological factors affected her physical condition. Commenting upon the issue of placing a permanent catheter in order for her to self-administer morphine, he notes:

> "She does not appear to be gaining any sort of secondary gain from her current injury. She does not appear an inherently addictive personality. She is not someone who would be necessarily psychologically ill-advised to take the proposed morphine treatment, however, she is quite frantic right now. Her reality testing and judgment are impaired, and she is having difficulty grappling with the fact of her physiological limitation. . . . [M.O.] should be given the morphine treatment only if it is judged to be a sound medical practice. For her part, she is willing to try just about anything right now." (Exhibit 8)

Respondent attempted to obtain permission from her medical insurance carrier to place a permanent epidural catheter for her, but was unsuccessful in doing so.

i. Respondent's approach to treating M.O. was to pursue combination therapies at a given time. During a single office visit, M.O. might receive epidural blocks containing both local anesthetic and steroids, with a stellate ganglion block and/or trapezius trigger point injection. A temporary epidural catheter was in place almost continuously. It was replaced whenever it was pulled out too far or otherwise associated with inflammation or nonfunction. Its replacement was not dictated by any apparent schedule.

j. From September 11 through 19, M.O. was hospitalized at Los Medanos Community Hospital for an infection at the site of the epidural catheter. Her final diagnosis was cellulitis C7-T1 interspace, organ streptococcus. It was a direct result of the epidural catheter placed at that site. At Respondent's instruction, M.O. had removed the catheter the day before prior to proceeding

to the hospital. During this hospitalization, M.O. was advised by William Johnson, M.D. that she was "addicted" to narcotics and that she should not return to the course of treatment that Respondent had been administering. M.O. began experiencing withdrawal symptoms at that same time, and felt that nursing staff were rude and treated her differently because she was a "junkie."

k. After her hospitalization, she weaned herself off the morphine and methadone. She refused to allow Respondent to place another catheter through which she could inject any more narcotics. She became very sick, with vomiting and sweating. Upon seeing her personal physician John Chokatos, M.D. and endocrinologist Todd Lorenz, M.D., she was admitted to Providence Hospital on November 13 with an initial impression of adrenal insufficiency manifested by tremulousness, sweats, weakness and hyponatremia. She was discharged on November 18, 1987 with no clear endocrine problem found except secretory defect. A CT scan showed normal adrenal glands. She was discharged on a regimen of hydrocortisone and maintained on same for approximately six months thereafter.

l. Respondent was aware of the potential side effects of long term steroid injections. His April 6, 1987 progress report notes:

> "I am starting to note some fullness in [M.O.'s]" face. It is apparent that we are starting to see some side effects from the steroid injections. However, I will continue to pursue these injections and try to stretch out the time in between injections in an attempt to minimize any side effects from the steroids."

Respondent opined on January 25, 1988 that M.O. "had developed an Addisonian type picture probably from the aggressive use of the epidural steroid injections and presently is being treated by an endocrinologist." He now disputes such diagnosis or linkage to his treatment. Hospital tests indicated that she had no adrenal shutdown, and that her adrenals were functioning normally.

Accusation Allegations – Patient M.O.

14. *Accusation Paragraph 28A* – Complainant alleges that Respondent in a grossly negligent and/or negligent and/or incompetent manner, employed the use of multiple epidural steroid injections in an excessive manner which directly led to the suppression of the hypothalamic pituitary adrenal axis in Patient M.O., hence the development of Addison's disease.

Epidural steroid injections are quite useful for treating a variety of chronic pain syndromes. Michael C. Rowbotham, M.D. opines that the limitation usually observed for this procedure is for the injections to be performed at approximately two week intervals for a total of 3 injections every six months in order to prevent suppression of the hypothalamic pituitary adrenal axis. Respondent performed 24 steroid injections over eight months. He suggests that risks for excessive steroid use include adrenal insufficiency if the nerve blocks were discontinued, injury to the ligaments in the spine, osteoporosis and chronic inflammation and scarring including arachnoiditis.

In this case, several factors mitigate in Respondent's favor. First, he was aware of expected side effects of

epidural steroids and monitored M.O. carefully, as his April 6, 1987 progress report indicates. Second, he was careful to inject only the physiologic dose needed to minimize toxicity. For example, on April 24, 1987, he reports that she was receiving an average of 4 mg of Prednisone a day (40 mg. Depo-Medrol over ten days) and that this amount "is physiologic and should allow us to continue the steroid injections." Respondent reasonably argues that the danger with steroid injections is the total *dosage* over time, and not the total number of injections. He also believes that steroids would be most effective if administered locally, and not orally. To the extent that risks were associated with long term injection of steroids, Respondent recalls discussing same with M.O. Third, it was not established that M.O. developed Addison's disease (adrenal insufficiency) or any other abnormality of her hypothalamic pituitary adrenal axis. Interestingly, M.O. was discharged in November 1987 with a finding of normal adrenal gland functioning, and placed on a six month regimen on the steroid hydrocortisone. Such finding and her steroid regimen run counter to criticisms that Respondent provided her epidural steroid injections in an excessive manner prior to her hospitalization.

For these reasons it was not established that the multiple epidural steroid injections employed by Respondent were either excessive or that they led to her development of Addison's disease or related adrenal crisis.

15. *Accusation Paragraph 28B* – Complainant alleges that Respondent failed to design an adequate long-term treatment plan for patient M.O. deciding instead on performing invasive procedures, from one office visit to the

next, dictated by short term responses only. Dr. Rowbotham opines that there is no indication anywhere on the notes that an adequate long-term treatment plan was in place and that upper limits existed on the intensity with which he planned to use the highly invasive means of pain control.

While a treatment plan was not developed as part of his initial history and physical, Respondent was still in the diagnostic stage and planned on administering a differential thoracic epidural block to confirm the sympathetic component of her pain. Within weeks, Respondent had prepared a letter to the referring physician reporting on his findings and recommending a treatment plan for M.O. (Finding 13d and 13e).

Thereafter he maintained fairly detailed progress reports which commented on changes in treatment dictated by her short term responses to therapy. Throughout, his rationale for given treatments are explained. In the context of her demonstrating progressive long term benefits, this approach was consistent with his earlier treatment plan. It was not established that Respondent failed to design an adequate long term treatment plan for M.O.

16. *Accusation Paragraphs 28C/28D* – Complainant alleges that Respondent in a grossly negligent and/or negligent and/or incompetent manner, used morphine on an ongoing basis to control M.O.'s pain, and that he improperly employed the prolonged use of temporary catheters in her care and treatment.

The medical opinion of Board expert Marvin H. Lipton, M.D., though reflective of the more conservative and objective approach taken by many orthopedists, was

largely disregarded in that he would seem to limit the use of epidural injections of morphine to patients with "metastatic disease, intractable pain, and a limited life expectancy." Dr. Rowbotham's concerns are similar but more qualified. He notes:

> "The risks of the epidural route do not justify the anticipated benefit. In addition, there are difficulties with prolonged injection into the epidural space on a daily basis with the ability of the drug to penetrate to its intended site of action other than by systemic absorption and redistribution to the area affected. The use of epidural opioids does not represent negligence but the prolonged use of temporary catheters would be considered negligent by most specialists in this area."

Dr. Rowbotham believes that a mitigating factor is that the catheters were continuing to be used on a temporary basis only because Respondent had not yet received approval for surgical placement of a sterile implanted epidural catheter system. The use of morphine on a long term basis via temporary epidural catheter for chronic non-malignant pain is clearly controversial. The analysis should therefore be individualized, and inquiry made on the more narrow issue of whether a physician in good faith believes that a patient suffering from injury or ailment requires such treatment, and then only in such quantity and for such length of time as are reasonably necessary.

Patient M.O. was a very complicated case. She had already received a number of other pain therapies prior to seeing Respondent (Finding 13c), and he continued to take a combination therapy approach in developing a

treatment plan for her. It included physical therapy and psychiatric evaluation, even on the specific issue of whether proposed morphine treatment would be appropriate (Finding 13i). It is clear that he followed her very carefully and that his choices for intervention were neither haphazard nor arbitrary. It appears from Respondent's medical records and from his testimony that he believed in good faith that M.O.'s condition required such morphine injections, and that he administered it in such amounts and for such time as he believed reasonably necessary at the time. In fact, Dr. Rowbotham did not believe that the total number of epidural opioid injections reflected gross negligence. It was his concern about self-injection that raised it to the level of gross negligence.

Respondent's use of temporary catheters looked ahead to insurance approval of a permanent epidural catheter, and under these circumstances Respondent cannot be faulted for using them as an interim measure. For all the above reasons it was not established that Respondent's use of morphine on a long term basis for M.O.'s chronic pain, or his use of temporary catheters in her care and treatment, departed substantially from the standard of care.

17. *Accusation Paragraph 28e* – Complainant alleges that Respondent improperly encouraged and allowed M.O. to self-inject opiate medications through an epidural catheter.

Notwithstanding Respondent's care in training M.O. to self-inject opioid medications through her epidural catheter, allowing her to do so departed substantially

from the standard of care. At a minimum, a visiting nurse or home therapies group should have been administering the injections. There is a high potential for infection or dosing error. A medically trained person should perform the procedure and observe the site for evidence of problems including infection. A lay person is not so qualified. One of Respondent's entries indicates that M.O. and her husband would manipulate the catheter by slowly pulling it out in order to get an adequate injection. This is clearly not a simple and safe procedure for patients to perform on their own.

Board expert Michael Levin, M.D. opines that "allowing the patient to self-inject entails a high risk of infection in the epidural or intrathecal space, leading to permanent neurological damage or even death." While this risk is well recognized when allowing terminal cancer patients to self-inject, it would not be acceptable for non-cancer patients. This is a straight benefit/risk approach. For chronic non-malignant pain, the risks clearly outweigh the benefits of self-injection.

Respondent cites a journal article in support of allowing patient self-injection of morphine for non-cancer pain, but even that article points to the dangers and limitations of this practice and it does not purport to set the standard of care.[2] Similarly, Respondent's parallels to diabetic self-

---

[2] Plummer, John L. **Long term spinal administration of morphine in cancer and non-cancer patients – a retrospective study;** Pain 1991; 44:215-20. This study followed 313 patients who had been treated with spinal morphine via an implanted Port-A-Cath. Twelve were non-cancer patients. The author notes:

injections are not at all analogous. First, such injections are intramuscular, and not into the epidural space. Second, the consequences of not having such done by the patient when needed can lead to diabetic shock, coma or worse. The balance clearly weighs in favor of diabetic patient self-injection in such cases. The same is not true for chronic non-cancer pain.

It was established that Respondent in a grossly negligent and incompetent manner encouraged and allowed M.O. to self-inject opiate medications through an epidural catheter. M.O. began self-injecting morphine in June 1987, and continued until her hospitalization in September 1987 for an infection at the catheter site (Finding 13j), the very risk associated with self-injection.

> "Our reporting of [non-cancer] patients should not be construed as a recommendation for indiscriminate or widespread use of spinal opioids in this patient group. Patients reported here represent a small and highly selected subgroup of over 3000 patients with chronic non-cancer pain seen in our unit during the period of the study. Usually this form of treatment would be adopted only when all other appropriate therapies have failed."

The study indicated that of these twelve patients, the spinal catheter was discontinued in five cases where the patients died, in three cases due to infection and in two cases where the patients experienced pain on injection/inadequate analgesia. Pain spontaneously resolved or the treatment was completed in the remaining two patients. This study cannot be read as recommending patient self injection for control of chronic non-cancer pain, and indeed the author acknowledges that this remains a controversial issue. (*Id.* at p. 219.)

18. *Accusation Paragraph 28F* – Complainant alleges that Respondent issued prescriptions to M.O. and authorized refills of prescriptions for morphine in large quantities resulting in her becoming addicted to same.

The definition of addiction includes a behavioral component characterized by psychological dependence and aberrant drug related behaviors. (See Finding 7.) Physical dependence and tolerance are normal physiologic consequences of extended opioid therapy and are not the same as addiction. While M.O. experienced painful withdrawal symptoms associated with her physical dependence on morphine, it was not established that her dependence was psychological or that she exhibited other aberrant drug related behaviors. Therefore by accepted definition, M.O. was not an addict. It was also not established that Respondent authorized refills of morphine for her. He continued to prescribe morphine each time her supply ran low, but this is different than authorizing refills.

19. *Accusation Paragraph 28G* – Complainant further alleges that after Respondent realized that M.O. had become addicted to morphine, he provided her with methadone and Valium to help her with her dependence on the morphine.

For reasons mentioned above, it was not established that M.O. was addicted to morphine. Successfully weaning oneself off morphine and methadone is not evidence that one was addicted to same.

20. *Accusation Paragraphs 29 and 30* – Complainant alleges more generally that Respondent's acts over the

relevant period of M.O.'s treatment constitute gross negligence, repeated acts of negligence, incompetence or repeated acts of clearly excessive prescribing or administering of drugs (controlled substances and dangerous drugs).

With the exception of patient self-injection, Complainant has not proven the above allegations. It has failed to present clear and convincing evidence to a reasonable certainty that Respondent's actions in treating M.O., though unusually aggressive, were in violation of the Code sections cited. (Business and Professions Code sections 2234 and 725.)

21. *Accusation Paragraph 32* – Complainant further alleges that Respondent's actions in furnishing a controlled substance (morphine and methadone) to a known addict or habitue without legitimate medical purpose constitutes unprofessional conduct.

M.O. was not a known addict. And Respondent did not provide her controlled substances solely for the purpose of providing her controlled substances sufficient to keep her comfortable by maintaining her customary use. Rather, he prescribed same with the good faith belief that her injury and pain required such treatment. It was not established that Respondent's furnishing M.O. with controlled substances constituted unprofessional conduct in this case.

Second Cause For Disciplinary Action

22. Treatment History – Patient M.G.

a. During the period that Respondent served as the Director of the Pain Clinic at Oak Knoll Naval Hospital in Oakland, he and his staff provided medical care and treatment for patient M.G. from October 1991, and continuing through the beginning of August 1993. The then 29 year old M.G. complained of chronic, acute and recurrent back pain. He had initially injured his back in 1988 while helping to unload a Medivac flight.

b. In June 1988, M.G. underwent a hemilaminectomy for decompression of his nerve root at L5 and S1. In December 1988, due to continued back pain, he underwent a second laminectomy which included a two level fusion (L4, L5 and S1) with a bone graft. He received some relief from his chronic back pain, but was subsequently hospitalized from July 22-24, 1991, due to spinal instability, low back pain and left leg pain. M.G. had also received five to six epidural steroid injections with limited relief of symptoms. He had no history of methadone use prior to being referred to Respondent in late September/early October 1991.

c. The earliest record (Exhibit 39 – consultation sheet) of Respondent's examination of M.G. states only that:

> "29 year old status post two level laminectomy and fusion, now with positional sharp pain and non union. Pain probably non-union related. Has failed epidural steroids in past times five. Will try methadone – if fails consider diagnostic block."

There is no written record of Respondent or his staff conducting a more extensive medical history or physical examination at the time of M.G.'s initial evaluation at the Oak Knoll Naval Hospital Pain Clinic. Navy medical protocol provides for one complete set of comprehensive medical records for patients, and these were not maintained at the pain clinic. They were not among the records retrieved by Complainant as part of the medical records offered at hearing. Respondent notes that pain clinic records were never intended to be the complete records of everything done medically for patients at Oak Knoll, and are not the official records for M.G. He also maintains that an *adequate* history and physical examination were performed. He does not assert that a *complete* history and physical examination were done, or that such are a part of the official medical records maintained by the Navy.

d. Respondent prescribed for M.G. a trial of methadone with good results. He initially prescribed 1-2 pills (5 mg) to be taken as needed every 6-8 hours. For the first month, one pill was enough to reduce M.G.'s pain, and then he upped it to two pills as prescribed. Respondent prescribed no additional medications, adjunctive physical therapy or other treatment.

e. Over the one year period from October 1991 to October 1992, M.G. increased the amount of methadone he was taking from 1 to 20 pills per day. On October 19, 1992, M.G. underwent a third surgical back procedure, a repeat transverse process fusion L4 to L5, and was discharged on October 27 in a full body cast. The cast was removed, refitted, and removed again in January 1993. Over the period of his rehabilitation, M.G. continued on

methadone, upping his daily intake to 30 pills, and then perhaps to as much as 35 to 40 pills per day. He would typically have an appointment with Respondent or his staff every seventeen days, and use such occasions to get refills in excess of the prescribed monthly dosage. He would lie to Respondent about losing pills. He also lied to Respondent about how much methadone he was taking. Respondent believed that M.G. was taking 20 pills/day, based upon M.G.'s misrepresentations. Respondent attempted to taper M.G. down to 15 pills/day, not knowing that M.G. was already up to 30 pills/day, and not 20. Respondent also tried non-narcotic analgesics without success. Lidocaine injections did not provide lasting relief, and other medications upset M.G.'s stomach.

f. M.G. became increasingly concerned over his dependence upon methadone. As he experienced more difficulty and agitation trying to taper down the methadone, he was admitted to the Oak Knoll Naval Hospital for methadone withdrawal. This was apparently his third withdrawal attempt. The plan was to decrease his daily methadone by 10 mg per day. At the time of his discharge on August 5, 1993, he had been off methadone for two days, and had been accepted into a prescription drug rehabilitation program.

g. On August 5, 1993, he was transferred to CPC Fremont Hospital for continued in-patient prescription drug rehabilitation therapy. His diagnosis at that time was opiate withdrawal, opiate dependence; rule out major depression. He was started on a detoxification protocol using Buprenex and Valium, and he then left against medical advice on August 7. He returned on August 9, recommenced the detoxification protocol, and

was discharged on August 17 with plans for followup care. He has remained free of methadone. As a part of his rehabilitation therapy, M.G. views himself as an addict, and believes that he was made so by Respondent.

Accusation Allegations – Patient M.G.

23. *First Supp. Accusation Paragraphs 12A-12E* – Complainant alleges that Respondent failed to perform a complete history and physical examination; and by failing to perform same could not initiate a treatment plan noting what objective factors would be used to evaluate the success of the treatment; and by failing to institute a treatment plan could not elevate the patient at periodic intervals using the original history and physical as a baseline.

Board guidelines call only for a diagnostic examination and an adequate medical history. Both are directed at arriving at a diagnosis and treatment plan. It is not necessary that a complete history and physical examination be performed in every case, particularly when patients are being referred by a primary physician for specific medical procedures or pain management. The history and examination need only be adequate for the purposes referred.

Dr. Levin opines after review of M.G.'s records that the failure to do a complete history and physical exam initially, and the failure to evaluate the patient thoroughly at each return visit, constitutes a departure from the standard of practice of medicine. He did not find such departure to be extreme. Respondent admits to performing an abbreviated physical examination, but avers that such was adequate for the purpose of addressing M.G.'s

specific complaints of pain. He also notes that the pain clinic records were not the official Navy medical records for M.G., and that he recorded detail sufficient only to jog his own memory and to guide his future treatment.

A major deficiency in Respondent's pain clinic records for M.G. is the lack of a specific treatment plan. There was not enough information charted to provide a reviewing physician an understanding of Respondent's thought process or the treatment plan and course. What often purports to be a treatment plan (e.g., "will try methadone – if fails consider diagnostic block.") is too abbreviated and incomplete. (See Finding 22c.) Too much is made of the fact that Respondent's pain clinic records were not official Navy records. Respondent has not also argued that a treatment plan would be expected to appear in the official Navy medical records. It would reasonably be expected to appear in Respondent's pain clinic records, and it does not. Because Respondent is aware of what is required, and indeed he complies with these requirements in other cases reviewed; and because the departure is not substantial, it was not established that his departure from the standard of practice constituted either incompetence or gross negligence on his part. His conduct did demonstrate negligence.

24. *First Supp. Accusation Paragraph 12F* – Complainant alleges that Respondent's failure to use other medications or treatment modalities constitutes negligence, gross negligence or incompetence. Accusation allegations specifically reference the failure to consider treatment modalities for neuropathic pain such as tricyclic antidepressants, antiseizure medications, physical therapy to

improve range of motion and muscle strength and psychological counseling and support if available.

There is no evidence that M.G. had neuropathic pain. Physical therapy was being managed for M.G. through his surgeon and Respondent considered it improper for him to intervene. Psychological counseling was sought and ongoing. These Accusation allegations were not established.

25. *First Supp. Accusation Paragraph 12G* – Complainant alleges that Respondent incompetently and/or negligently and/or grossly negligently taught, encouraged and/or allowed patient M.G. to self-administer methadone, on an as needed basis.

Board expert Dr. Levin opines that in prescribing methadone for chronic pain patients, the patient should be allowed to take the narcotic on a time-dependent rather than a pain-dependent dosing schedule. He believes that the dose should be rigidly dictated by the physician, and not by the patient. Here, Respondent prescribed 1-2 pills of methadone (5 mg) to be taken as needed every 6-8 hours. Dr. Levin believes that the dose should instead have been a fixed amount to be taken every six or eight hours. His rationale is that methadone is a well-absorbed oral narcotic with a long half life, and because of this it needs to be maintained in the bloodstream at a fairly constant level. The regular timing of doses also gets away from problems of patient psychological dependence on short acting narcotics.

Respondent agrees in principle that methadone should be taken on a time dependent basis, but feels that

Dr. Levin's approach is too dogmatic and not the standard of care. There should be some allowance for flexibility, and he believes that setting the outer parameters of a dose (e.g., 1-2 pills every 6 to 8 hours) is within the standard of care. In support, Respondent offers a recommended table for methadone administration contained in the September 1995 edition of *Anesthesiology News* (Exhibit X) which offers the following comment: "dosing should start on prn [as needed] basis with close monitoring."

Regardless of whether it is better to be on a strict time dependent basis, it appears that the general practice has been mixed, with both approaches finding support. Respondent does define the outer parameters for methadone intake by amount and time so that it is not prescribed on an absolute as needed basis. His methadone dosing is subject to an element of physician control, albeit not strict. It is also consistent with his philosophy of patient autonomy and participation in pain management. For these several reasons, it was not improper for Respondent to prescribe methadone as he did to M.G. on an as needed basis within the stated parameters of amount and time.

26. *First Supp. Accusation Paragraph 13* – Complainant alleges generally that Respondent's actions in treating M.G. over the relevant period constituted repeated acts of negligence, gross negligence, or incompetence. The thrust of the charges look to whether Respondent caused M.G. to become addicted.

The psychological element appears to be present. Within months of beginning the medication program

M.G. began lying to other physicians in an effort to secure additional methadone. He went to the V.A. Hospital in Palo Alto to get more methadone and made up a story about who was treating him in order to protect Respondent. When his intake of methadone escalated to between 35 and 40 pills per day, he was reporting to Respondent and his associates at Oak Knoll Naval Hospital that he was only taking half that amount. He also lied about losing the pills when he had not in order to obtain another month's supply. The efforts to enroll and then maintain him in a detoxification program also point to his dependency problem. Even while recognizing that he was experiencing severe difficulties in attempting to control his methadone intake, M.G.'s own attempts to stop the methadone or to taper it were complicated by violent behavior, diarrhea and nausea.

It was therefore fairly established that M.G. became addicted over time to methadone, and that intensive measures were needed to wean him off methadone and then to keep him off. The more difficult issue is whether Respondent's practices in prescribing him methadone over this period were within the standard of care. Board expert witness Dr. Michael Levin opines that Respondent did *not* make M.G. an addict. (RT 1/10/96, p.19) He also was not as concerned about the amount of methadone prescribed to M.G. as he was about the fact that it was done so on an as needed basis. In his October 9, 1994 report to the Board, Dr. Levin finds many elements around M.G.'s treatment to criticize, but he does not find that Respondent's actions contributed to his becoming an addict. His criticisms around methadone administration relate only to the prn dosing and Respondent's failure to

use other adjunctive medications prior to the institution of long term narcotics.

Although M.G. did become addicted, there is no evidence that Respondent was on notice that he was exhibiting drug seeking or other aberrant behavior as above described. He made a good faith determination that M.G. was suffering from an injury which required such treatment. There was objective evidence of his pain following nonunion of his spine. Respondent reasonably relied upon M.G.'s reports of methadone intake, which turned out to be only a fraction of what he was actually taking. That M.G. was seeing several of Respondent's associates at the Navy clinic further complicated Respondent's ability to adequately monitor M.G.'s drug seeking behavior. In hindsight it is clear that M.G. was addicted. But at the time methadone prescriptions were made, they were done in good faith and in amounts believed necessary to address M.G.'s pain. They were not merely prescribed to keep M.G. comfortable or to maintain his customary use. Most important, the Board's own medical expert apparently does not believe that Respondent made M.G. an addict.

To the extent that Respondent was negligent over the relevant period, such relates primarily to his failure to institute an objective, measurable treatment plan against which future progress could be gauged at periodic intervals. It was not established that his conduct in administering methadone demonstrated repeated negligent acts, gross negligence or incompetence.

27. *First Supp. Accusation Paragraph 14* – Complainant further alleges that Respondent's actions constitute

repeated acts of clearly excessive prescribing or administering of drugs (methadone).

By reason of the matter set forth in Findings 25 and 26, it was not established that Respondent's prescribing of methadone to M.G. on an as needed basis, or at a time that he began exhibiting drug seeking and other aberrant behavior, was improper. Respondent acted in good faith upon the information reasonably available to him at the time. Apparently, M.G. was a convincing patient. The fact that he had other measurable and objective medical findings certainly did not hurt his case for pain. He reasonably appeared to Respondent as an intractable pain patient, and was treated accordingly. The fact that Respondent and others were ultimately duped into providing M.G. additional methadone does not transform their actions into clearly excessive prescribing or administering of controlled substances (methadone). This allegation was not established.

Fourth Cause For Disciplinary Action

28. *Treatment History – Patient M.H.*

a. Respondent first saw patient M.H. on January 29, 1993. She was then age 39, and presented with complaints of dull throbbing ache with an occasional sharp stabbing pain primarily in her back and occasionally down her legs. Her pain related back to a motor vehicle accident in April 1983. She had been followed by several physicians and had been treated in the past with Vicodin, anti-inflammatory and epidural blocks (7-8 epidural steroid injections), acupuncture and chiropractic. At the time of

her first visit with Respondent, M.H. was taking medications including Mellaril, Doral and Zoloft. She had not undergone any surgical intervention before seeing Respondent. She reported her pain to be a 7 on a 0-10 scale. M.H. had been referred to Respondent by Jeffrey White, M.D. for evaluation and treatment of severe recalcitrant low back pain with occasional leg pain, especially for consideration of an implanted intraspinal narcotic infusion pump.

b. She had a documented history of psychosis, depression and suicidal ideation as well as multiple actual suicide attempts. She also had undergone electroshock therapy. It was reported to Respondent that she had used cocaine recreationally about a year prior to seeing him, but that she was no longer using street drugs. Respondent considered her to be a complex patient and given her psychological history including past suicide attempts, he expressed concern to Dr. White that "she might be having such high expectations for me that a failure on my part to help her might cause her to seriously consider suicide again." (Exhibit 50)

c. Over the period February 1 to February 16, 1993, M.H. saw Respondent for six office visits. On February 2, Respondent performed a spinal block using a local anesthetic (Lidocaine 50 mg) and a short acting narcotic (Fentanyl 50 mcg) which M.H. tolerated well and which provided complete pain relief. On February 3, M.H. was seen by Mark Lemons, M.D. He performed a second spinal block using Lidocaine (50 mg) and Fentanyl (100 mcg) which she tolerated well, except for an allergic reaction (pruritus) treated with Benadryl.

d. On February 4, Respondent, noting that there was no overall incremental improvement, performed a diagnostic intravenous Lidocaine infusion, beginning with 50 mg with an additional 150 mg for a total of 200 mg. This was followed by a trial prescription of Mexiletine.

e. On February 8, Respondent noted that M.H. did not tolerate the Mexiletine. He decided to give her a methadone trial, starting her on 1 to 2 tablets (5 mg) every 4 to 12 hours as needed for pain. A total of 50 tablets were prescribed. He discussed the need to titrate her dosage upward to her needs. A followup visit was scheduled for the next week.

f. On February 16, M.H. reported to Respondent that she had been taking two methadone every four hours, and that it had essentially no effect on her pain. Respondent noted that M.H. reported a previous history of street drug use, primarily cocaine, which could be affecting her tolerance. Respondent also noted that M.H.'s psychologist was pleased by her progress. He avers that her psychologist gave M.H. a note to give to Respondent, asking him to consider the possibility of facet injections. Given her very low L-5/S-1 area tenderness, Respondent felt that a facet block might be given future consideration. At the end of the visit, Respondent again prescribed methadone, 3 to 4 tablets every 4 to 6 hours as needed for pain. A total of 200 tablets were prescribed, making available to her 1,000 mg of methadone. His treatment plan consisted of increasing her methadone, reevaluating her based on this increased dosage, and having her return with imaging scans of her

back for consideration of placement of an indwelling narcotic infusion pump.

g. On February 19, M.H. was found, unconscious and unresponsive in her apartment. She was brought to the emergency room and admitted to Humana Hospital in San Leandro with an admitting diagnosis of presumed phenothiazine and methadone overdose and probable aspiration pneumonia. Her long psychiatric history and multiple suicide attempts were also noted in the admitting report. On the night before she was hospitalized, M.H. recalls taking only two medications, Mellaril and methadone. It was not established that any overdose was intentional or otherwise a suicide attempt by M.H. The two drugs taken in combination may have the effect of potentiating each other. The additional methadone that she took in combination with the Mellaril may have had a respiratory depressant effect.

h. She recalls taking the methadone, and then taking some more per Respondent's instructions that she should take the medication "as needed" for pain. The physician who followed her after admission, Eugenio L. Balbuena, M.D. noted in his history that the bottle of methadone was found to be full, so it does not appear that she took an excessive dose. Also, M.H. was twice administered Narcan, a drug that reverses the effects of a narcotics overdose, with no change in her level of consciousness. While it was theorized that her unconsciousness may have instead been due to hypoxia from aspiration pneumonia, which condition would not respond to Narcan, it still does not appear that M.H. intentionally overdosed on methadone.

Accusation Allegations – Patient M.H.

29. *First Supp. Accusation Paragraphs 26A/B*– Complainant alleges that Respondent incompetently and/or negligently and/or grossly negligently taught, encouraged and/or allowed patient M.H. to self-administer methadone, on an as needed basis.

It is argued that it should have been prescribed in a stated milligram dose every six or eight hours. Board medical expert Dr. Michael Levin made much the same argument with respect to patient M.G. (Finding 25) and it was determined there that methadone could properly be prescribed on an as needed basis within stated parameters of amount and time. However, Dr. Levin also points out that where a patient like M.H. has a known history of addiction to cocaine and street drug use within the previous year, there is more reason not to give her access to prn (as needed) medications. This reasoning is sound.

Respondent argues that patients should be free to adjust doses upward as activity levels increase or as tolerance develops. The fact that she had a history of suicide attempts was a factor to be considered, but only on the threshold issue of whether or not she was currently at risk for suicide. Even still, where a patient presents with a known history of both past cocaine/street drug use and past attempts at suicide, a physician is bound to assume far greater monitoring and control of methadone prescription. Certainly, Respondent could titrate doses upward as tolerance or activity levels increase. There are clearly ways that he could be responsive to changes in her need for methadone. For these reasons, Respondent's practice in giving M.H. methadone

on a prn basis was a departure from the standard of care (negligence). It was not an extreme departure from the standard of care, nor does it reflect physician incompetence or lack or knowledge or [sic] understanding of the pharmacology of methadone.

30. *First Supp. Accusation Paragraph 26C* – Complainant alleges that Respondent caused M.H. to undergo, without medical indication or justification, two spinal anesthetics with local anesthetic and narcotic; procedures without any diagnostic or therapeutic value. One of the two procedures was actually done by Dr. Mark Lemons. Dr. Levin opines that if the test was for purposes of evaluating future implantation of a narcotic infusion pump, such should be done with a narcotic alone. By combining two agents, one cannot tell which is providing the pain relief.

Respondent opines that the combination block does have diagnostic value. The local anesthetic has a very fast onset and will give indication if the patient has sympathetically maintained pain. If the pain is sympathetically maintained, you would expect to see a total relief, followed by a return of the pain and duration to a somewhat diminished level. The duration of pain relief may be upwards of three to four days from local anesthetic. If the pain returns within hours or with the same intensity one day later, it points to the narcotic as the active agent for pain relief.

Here, Respondent performed the block for purposes of evaluating M.H. for possible narcotic infusion pump, to determine whether there was any long term benefit from such block, and to see if her pain was neuropathic

or sympathetically maintained. It was established that the blocks were performed for diagnostic purposes, and therefore were not an extreme departure from the standard of care.

31. *First Supp. Accusation Paragraph 27* – Complainant alleges that the course of treatment and professional care provided to M.H. constitutes gross negligence, repeated acts of negligence or incompetence.

Respondent was aware of M.H.'s relevant recent psychological history. In his February 14, 1993 letter to Dr. White (Exhibit 50) he expressed specific concerns regarding her psychological state. He recalls contacting her psychiatrist, Dr. Scott, and references same in a separate letter to the sister of M.H. He also references her street drug use in the February 16 progress note, along with a reference to a recommendation by a psychologist that "Versed" (read facet) injections be considered. Complainant attempts to lay responsibility for M.H.'s overdose on Respondent. The record is not clear as to whether M.H.'s overdose was intentional, or whether it was even attributable to an overdose of methadone. (See Findings 28g and h.) Because methadone and Mellaril potentiate the effects of the other, it may be that her overdose was accidental. Regardless, even Board expert Dr. Levin indicates that he did not focus on this incident, and that he did not see this as a major problem that Respondent had contributed to.

Respondent's negligent treatment of M.H. relates primarily to his prn dosing of methadone for reasons already set forth above in Finding 29.

32. *First Supp. Accusation Paragraph 28* – Complainant alleges that Respondent's use of spinal anesthetics

constituted repeated acts of clearly excessive use of diagnostic or treatment procedures.

There were only two spinal blocks, only one of which was performed by Respondent. For reasons already discussed in Finding 30, these procedures did not constitute repeated acts of clearly excessive use of diagnostic or treatment procedures.

Fifth Cause For Disciplinary Action

33. *Treatment History – Patient B.C.*

a. Patient B.C. was a 37 year old man with a history of cat scratch fever, resulting in the removal of cysts on the left side of his neck. Following partial removal of the cysts, first in 1987, and again in 1988 for a recurrent mass, B.C. experienced pain (chronic trigeminal neuralgia) and was treated for same at Kaiser. Eventually, Kaiser physicians Dr. Golfus and Dr. Matus referred him to Respondent for an initial diagnostic block and further evaluation/treatment of his symptoms. This was on February 1, 1990. By then he had already undergone a number or [sic] treatments with physicians and therapists without effect.

b. On his first visit, B.C. completed a fairly extensive medical history on a form utilized by Respondent's pain relief center. Respondent did not perform a physical examination because B.C. was referred to him for a particular procedure, and Respondent viewed his role as an information gatherer and consultant for the Kaiser physicians. The relevant treatment history between February

and April 1990 is well summarized in Exhibit 71 and follows:

> "On February 1, 1990, the patient underwent thoracic epidural anesthetic with 0.5% Lidocaine, experiencing complete relief of his pain symptoms. Dr. Day made the diagnosis of sympathetic dystrophy. On February 2, 1990, he underwent repeat thoracic anesthetic, however there was still pain in the left neck and he underwent trigger point injections which relieved his pain completely. On February 8, 1990, he underwent another thoracic epidural anesthetic. He was not seen again until March 27, 1990, having undergone a neuroma excision during that time. His pain was not improved. On March 27, 1990, he underwent left stellate ganglion block with 5 mg morphine in addition to 10 cc 1% Lidocaine and experienced relief. On March 28, 1990, he again underwent left stellate ganglion block with Lidocaine and morphine. On March 29, 1990, he underwent epidural thoracic catheter placement with injection of 0.5% Lidocaine, 50 mg Demerol, and 80 mg Depo-Medrol.
>
> On April 2, 1990, it was noted that he received six hours of pain relief from the Demerol injection. He underwent thoracic epidural catheter placement again and was injected with 5 mg morphine and 5 cc 0.5% Lidocaine, which was then repeated 30 minutes later. He was discharged home following the thoracic epidural injection of morphine. On April 3, 1990, the patient returned, noting 10 hours of relief following the epidural morphine injections."

c. On April 10, 1990, Respondent wrote to Dr. Matus and suggested three treatment options for B.C. Treatments up until then provided relief for only a short period of time, and the absence of any incremental improvement prompted Respondent to suggest that the following be considered: 1) a neurolytic stellate ganglion block, 2) a surgical stellate ganglionectomy or 3) an implanted intraspinal narcotic infusion pump. With regard to the narcotic infusion pump, Respondent did not feel he should really consider this alternative until B.C. was evaluated by a surgeon, or B.C. had refused surgery or had failed to obtain adequate relief following surgery.

d. On October 2, 1990, Respondent performed Phenol trigger point therapy by injecting a small amount of 0.5% Marcaine into the scar on B.C.'s neck. The procedure was repeated after a half hour with 1 cc of 6% aqueous Phenol solution. B.C. obtained good but not complete pain relief. On October 8, the procedure was repeated with injection into the subcutaneous tissues deep into the scar on the left side of B.C.'s neck.

e. B.C. was also seen at the UC Davis Neurosurgery Department and had both a dorsal root rhizotomy and an intraspinal narcotic infusion pump recommended. About this time Respondent was called to active duty at the Oakland Naval Hospital during Operation Desert Shield and had advised B.C. to consult his primary care physician for ongoing and followup care.

f. On December 6, 1991, at the request of B.C. and in order to have Kaiser medical plan cover the costs associated with the surgery, B.C. was admitted to Kaiser Hospital in Vallejo for the attempted insertion of an intrathecal

narcotic infusion pump by Respondent. The procedure was done under general anesthesia. A small incision was made at the T5-T6 interspace and multiple unsuccessful attempts were made to enter the intraspinal space. A 14 gauge epidural needle was used. Respondent then moved one space further up where again, multiple unsuccessful attempts were made. Both a 14 and 22 gauge epidural needle were used to enter the intraspinal space. A further incision was made to join the two sites and to deepen the incision in order to allow attempts to enter the subarachnoid space. Multiple attempts were again unsuccessful.

g. Respondent then attempted entry from various positions, including midline and to the right of the paramedian approach, without success. On one occasion when Respondent felt that the subarachnoid area had been entered, he retrieved free flowing bloody fluid. B.C. developed bigeminy and the anesthesiologist had to administer Lidocaine to return him to a normal sinus rhythm. Respondent next attempted to enter the subarachnoid space in the lumbar area and inserted a 22 gauge needle at the L1-L2 area where he obtained grossly bloody fluid. The attempted procedure was thereafter aborted. At no time during the procedure did Respondent use fluoroscopy.

h. As a result of the above described operation, B.C. suffered catastrophic complications. These included pneumothorax, epidural bleeding, and postoperative lower extremity paralysis. An emergency MRI revealed evidence of a small spinal cord contusion at the thoracic level. B.C. remained hospitalized for eleven days before

he was discharged with home nursing care and physical therapy for his paraplegia.

Accusation Allegations – Patient B.C.

[Gross Negligence, Repeat Negligence, Incompetence]

34. *First Supp. Accusation Paragraphs 45A-E* – Complainant alleges that Respondent failed to perform a complete history and physical examination, did not initiate a treatment plan noting what objective factors would be used to evaluate the success of the treatment, and did not evaluate the patient at periodic intervals, using the original history and physical as a baseline.

An adequate history was obtained. (Finding 33b) Board expert Dr. Levin was shown relevant portions of B.C.'s medical records and he now opines that an adequate history and physical examination were performed. B.C. was referred to Respondent for specific procedures – initial diagnostic block and further evaluation and treatment of his symptoms. Under these circumstances, all that was necessary by way of history and physical examination is confirmation that the requested procedure is reasonable. That was done here. There was an initial history and physical taken by Respondent that could later be used as a baseline. Respondent did not consider himself as B.C.'s primary treating physician and the overall treatment plan for B.C. was the responsibility of his Kaiser primary physician. These Accusation allegations were not proven.

35. *First Supp. Accusation Paragraph 45F* – Complainant alleges that prior to proceeding with a narcotic infusion pump Respondent failed to use other medication trials or treatment modalities. Examples offered are tricyclic antidepressants, antiseizure medications, antiarrhythmic medications, Capsaicin cream, oral narcotic or physical therapy to improve range of motion and muscle strength, and psychological counseling and support.

Respondent again points out that he was not the primary care physician, and that this was not his role. Something more than conservative pain management was sought for B.C. For this same patient, two other physicians after a single visit recommended in one case a neurosurgical procedure without any trials, and in the other case implantation of electrodes in the brain.

Respondent presented the three more aggressive interventions (Finding 33c) only after it was apparent that treatment up until then provided only temporary relief with no incremental improvement. B.C. did undergo psychological counseling in reference to recommended procedures. For these reasons, the allegations were not sustained.

36. *First Supp. Accusation Paragraph 45G* – Complainant alleges that Respondent's manner of using combination (morphine plus Lidocaine) blocks made any diagnosis derived from same suspect.

Dr. Levin opines that morphine clouds the diagnostic picture when used in a diagnostic stellate ganglion block and makes the test of no value. Respondent explains that the diagnosis of pain is easily distinguished at that level, and that because he had earlier made the diagnosis prior

to the use of morphine, the addition of morphine was meant to be therapeutic, not diagnostic. The diagnosis was considered easy to make in this case because of the substantial anatomical separation of the sympathetic (T2-T4) and sensory nerves (C2-4). Respondent's reasoning is rational. It was not established that his use of combination blocks departed from the standard of care.

37. *First Supp. Accusation Paragraph 45H* – Complainant alleges that there was no clear indication for using steroids for B.C.'s condition, and also that Respondent administered high does of oral or intravenous narcotics without appropriate respiratory monitoring. Epidural steroids are acceptable for treatment of sympathetic pain syndromes, and Respondent had initially diagnosed sympathetic dystrophy (Finding 33b). His use of epidural steroids was not inappropriate.

Respondent gave B.C. the narcotic antagonist Naltrexone on March 23, but not on March 27 or 28. His reasoning is that B.C. was either given oral Naltrexone or otherwise demonstrated insensitivity to narcotics. Dr. Levin opines that patients should have hourly respiratory checks for 24 hours following epidural narcotic injections. It was not established that Respondent's use of Naltrexone and clinical observations following epidural narcotic injections were outside the standard of care.

38. *First Supp. Accusation Paragraph 45I* – this allegation relates to matters previously discussed in Findings 30 and 36. Respondent's use of combination blocks (narcotic and local anesthetic) as a diagnostic test prior to consideration of an intrathecal narcotic infusion pump was not outside the standard of care.

39. *First Supp. Accusation Paragraph 45J* – Complainant alleges that Respondent's decision to attempt to place an intrathecal narcotic pump was premature given the lack of more conservative measures.

This decision was made by B.C. in conjunction with his primary care physician. B.C. also had psychological counseling specifically related to this procedure before it was approved by his primary care physician. Respondent did not even see B.C. for the year preceding the procedure, during which time he had advised B.C. to consult his primary care physician for ongoing and followup care. This Accusation allegation was not established.

40. *First Supp. Accusation Paragraph 45K* – Complainant alleges that Respondent's decision to place the infusion catheter at the thoracic level demonstrated a lack of knowledge of both how the catheter is inserted and how intrathecal morphine circulates in the cerebral spinal fluid. The allegations are based on Dr. Levin's opinion (Exhibit 71) which follows:

> "Intrathecal morphine is hydrophilic, meaning that it will circulate freely in the cerebrospinal fluid. Narcotic infused at the lumbar level, where it is much safer to place the catheter, would achieve the same concentration at the thoracic level as a catheter placed at that level. Furthermore, the catheters are designed to be threaded from the lumbar region below the spinal cord upwards under fluoroscopy, so that if it was necessary to place a catheter at the thoracic level, it should have been done from an insertion point at the lumbar level. If Dr. Day felt that it was necessary to place the catheter through a thoracic entrance site, as he did, then it should

> never have been performed under general anesthetic. Fluoroscopy should have been utilized for assisting placing of a needle. . . . When placed correctly in the lumbar region, for the correct indications, under local anesthesia, it is a very safe procedure."

Respondent believes that upper thoracic placement was important because of the need to have morphine diffuse directly into the level where it would work. He suggests that lumbar placement of the catheter leads to concentration of narcotic in the sacral portion of the spinal cord leading to possible urinary retention. He also believes that threading the catheter upwards with the stilette runs a risk of damaging nerves along the spinal cord leading to injury. Respondent notes that the catheter has a lower specific gravity than cerebrospinal fluid and that it would tend to drift down over time, with nothing to support it once the stilette is removed. Finally, Respondent views fluoroscopy as something causing more interference than help. There is a risk of radiation damage to metabolically active sites (e.g., bone marrow). He did not believe it to be useful. He also believes that under a straight risk/benefit analysis, there was less danger of hitting and damaging the spinal cord at the thoracic than lumbar level.

Dr. Levin's medical opinion is more persuasive. Although morphine may not be completely hydrophilic, it will reach equilibrium state over time in the cerebrospinal fluid, and if threaded upwards from the lumbar region, it will more closely approximate thoracic placement. Lumbar placement is safer and experience indicates that excellent relief can be gotten in the upper extremities

from same. Given the greater risks associated with thoracic placement, fluoroscopy should have been utilized. It would have been an additional safeguard against the possibility of pneumothorax, and would have indicated when the needle was approaching the intrathecal space. Respondent's actions without fluoroscopy resulted in pneumothorax, epidural bleeding and postoperative lower extremity paralysis (see Findings 33f-h).

By reason of the above, it was established that Respondent's decision to place the infusion catheter at the thoracic level and without the use of fluoroscopy represented an extreme departure from the standard of care. It also exhibited a lack of knowledge and ability in carrying out his professional medical obligations.

41. *First Supp. Accusation Paragraph 45L* – Complainant alleges that placement of the intrathecal infusion pump under general anesthesia was also a departure from the standard of care. Dr. Levin opines that general anesthesia is not generally used for this procedure because a patient's response is needed to determine whether any neural structures are being irritated.

Respondent has performed similar procedures under general anesthesia with the assistance of another physician. He has also performed comparable procedures under local anesthetic. At no time was he told that it was either inappropriate or dangerous to perform such under general anesthesia. In this case, he believes that it would have made no difference if B.C. was awake. The injury to his spinal cord would still have occurred. It may have been the better practice to perform this procedure under

local anesthetic, but it was not established that Respondent's use of general anesthesia, taken alone, was an extreme departure from the standard of care or that it reflected incompetence on his part. It was a departure from the standard of care and therefore constituted negligence. However, in combination with attempted thoracic placement of the intrathecal infusion pump without fluoroscopy, it constituted an extreme departure from the standard of care.

42. *First Supp. Accusation Paragraph 46* – The general allegations of gross negligence, negligence or incompetence have been addressed in Findings 34 through 41. Only Accusation paragraphs 45K and 45L were sustained regarding Respondent's placement of an intrathecal infusion pump at the thoracic level without the use of fluoroscopy and under general anesthesia. Such action constituted gross negligence and exhibited a lack of knowledge and ability in carrying out his professional medical obligations.

Sixth Cause For Disciplinary Action

43. *Treatment History – Patient J.W.*

a. On August 28, 1986, Respondent first saw patient J.W., a then 34 year old female with complaints of chronic, acute and recurrent pain in her left foot and leg. She had injured her left knee in September 1979, and had since had numerous surgeries including a surgical fusion of her left knee joint, reportedly as a pain control measure. A patient history was taken and a physical

examination performed by office staff. (Exhibit FF) In his August 28 progress report, Respondent noted:

> "She is a 32 year old female who has a long history of sympathetic dystrophy of the left leg. This has been well evaluated and aggressively treated in the past. She has received numerous sympathetic blocks in the past. These resulted in relief of pain in the leg, but she has never gotten long term relief from these injections. She has also received intravenous regional Reserpine with relief of the pain, but again, no long term relief.
>
> She has had epidural steroids in the past, and this has not given her any long term relief. She is a good candidate for a neurolytic injection, but before I do that, I need to document for myself that she does not receive relief from a series of local anesthetic injections, and that she can get good relief with a sympathetic block."

b. Beginning on September 2, 1986 Respondent began a course of treatment at the Walnut Creek Pain Relief Center consisting of daily nerve blocks via epidural catheter of 0.5% Lidocaine with DepoMedrol. The blocks provided limited relief. She was also started on methadone and Minipres, a medication described as helping to alleviate sympathetic dystrophies. Respondent did not recommend adjunctive physical therapy because her knee joint was fused and she had full function of her leg in that condition.

c. On September 12, 1986, Respondent decided to proceed with further epidural sympathetic nerve blocks, and these continued intermittently, mixed with DepoMedrol, through November 7, 1986. Methadone was

prescribed on a time contingent dosing basis, but she was instructed within these parameters to take it until pain relief was achieved. Respondent was aware that J.W. was seeing a psychiatrist at this time.

d. In October 1986, Soma (350 mg) three times daily was added to the methadone. Respondent noted in his October 28 progress report the following:

> "She also asked for some more methadone. I prescribed 100 tablets for her 6 days ago. She states that she takes on the average, 10 per day but she doesn't keep that close track of them. Looking back, her needs have been about 14 per day. This is a significantly large amount of methadone although she has been on narcotics for a very long time and has obviously developed a tolerance to them. We are obviously not going to be able to change this until we get control of her pain and I feel we are moving in that direction."

e. On November 12, 1986 a left neurolytic sympathetic block was recommended by Respondent. There had been a previous recommendation for a neurolytic block but her psychiatrist had recommended this not be done. He noted that an intravenous regional sympathetic block using Reserpine gave her about one week of pain relief.

f. In early 1987, J.W. underwent a sympathicectomy of her left leg at Stanford Hospital. Respondent did not see her again until August 6, 1987. He noted some improvement in her pain symptoms, but "certainly not a substantial or complete relief." She had been able to cut down substantially on her pain medication, but her pain continued to be a problem for her. Respondent opined

that there were two options remaining for her, spinal cord stimulation or an epidural narcotic injection. He describes the former as a "glorified TENS unit" and avers that in 1987 it was not clear that such provided any substantial relief, and was very costly besides. He went forward with placement of a lumbar epidural catheter, injecting 50 mg of Demerol in 5 cc 0.5% Lidocaine. It resulted in complete relief. The catheter was left in place and J.W. was scheduled to return the next day for a trial of Duramorph, which she received.

g. On August 11, 1987, Respondent taught J.W. to self-inject narcotics through the catheter port as an outpatient. After returning the next day for a demonstration she was discharged with supplies and Duramorph for self-injection for one week. She thereafter continued to self-inject narcotics through early May 1988. Over that period, J.W. also underwent numerous placements of the epidural portion of the Dupen catheter.

h. On March 17, 1988, a lumbar epidural catheter was placed, however, it was placed subarachnoid rather than epidurally. The March 18 progress report notes that:

> "[S]he is getting excellent relief with the subarachnoid injections and feels that the pain relief is even more profound than she gets with the epidural injections. In view of this response, we will leave the catheter in place and she will inject that and we will consider very early next week for changing her to a more permanent subarachnoid catheter."

i. On March 23, 1988, J.W. was having persistent leakage of cerebral spinal fluid (CSF) out of the catheter. Respondent noted that she was getting ineffective pain

relief probably because of the loss of fluid, and that she was not feeling well secondary to withdrawal symptoms associated with the leakage. The catheter was removed and CSF leakage spontaneously stopped. A midlumbar epidural catheter was placed and she was injected with 10 mg of morphine.

j. Between March 23 and May 6, 1988, J.W. experienced multiple problems with both temporary and permanent epidural catheters placed by Respondent. These problems included headaches and marked changes in mental status. The tip of the epidural catheter was either placed in the wrong space or it had migrated out of place causing the problems experienced by J.W. On April 19, 1988, Respondent removed an epidural catheter found on x-ray not to be in the epidural space. A replacement catheter was put in after two attempts. The replacement was the previously removed Davol silicone epidural catheter. Respondent did so as a cost saving measure, and indicates that it was sterilized prior to reinsertion.

k. She returned on April 20 with complaints of marked headaches and pain in her legs. The catheter was checked and it aspirated CSF, indicating subarachnoid placement of the catheter. The catheter was removed and it was arranged for her to be admitted to Los Medanos Hospital. She was disoriented, nauseated and continued with severe headaches. Respondent planned to schedule her for placement of a new epidural catheter under fluoroscopic control in the operating room once her other symptoms resolved. Further workup at the hospital revealed that J.W. had meningitis.

l. On May 8, 1988, J.W. was readmitted at Los Medanos Community Hospital for treatment of a reoccurrence of meningitis. At the time of her admission she had a temperature greater than 101, a white blood cell count greater than 15,000, and was complaining of a stiff neck and headache. Respondent had not done any procedures over the period between hospitalizations.

m. On June 1, 1988 at Los Medanos Community Hospital, Respondent placed a percutaneous DuPen long term catheter as well as permanent subcutaneous port for J.W. The catheter was placed using fluoroscopy. Thereafter narcotic injections resumed. On June 13, J.W. complained that the catheter had stopped working. X-ray indicated that it had backed out of the epidural space and on July 5, 1988, the nonfunctioning catheter was removed. J.W. was started on Roxanol (oral morphine) and this medication was continued until a neurosurgeon could place a permanent indwelling catheter into the epidural space so that a pump could be used to instill narcotics.

n. In August 1988, J.W. had a permanent indwelling DuPen catheter and Davol subcutaneous injection port placed by a neurosurgeon at the county hospital. On August 23, J.W. returned to Respondent and he provided her first injection into the newly installed port and provided her with a prescription for 25 gauge needles and Catapres, a drug that minimizes withdrawal symptoms. It was anticipated that she would have withdrawal symptoms after discontinuing oral narcotics. On August 28, 1988, J.W. reported that upon port injection, fluid was leaking out of the skin and that she was not obtaining good pain relief. Respondent determined that fluid was

leaking back along the catheter path and not staying in the epidural space.

o. Respondent continued to see J.W. intermittently through January 25, 1991, when he was recalled to active duty. Respondent was aware that she had been under reporting her use of medications and returning early for refills. There are no entries as to level of pain, activity level or side effects of the oral or injectable narcotics. Over this same period, J.W.'s mother had been diagnosed with cancer. Although Respondent recommended placement of a pump, J.W. believed that a pump would necessitate a greater number of office visits and interfere with her remaining time with her mother.

p. On J.W.'s last visit on January 25, 1991, Respondent persuaded her to go forward with placement of the pump, coverage for which had been previously authorized. In anticipation of that, he determined that a spinal block was necessary to assess dosage and to insure a good starting dose on her. A needle was placed subarachnoid in the L1-2 interspace and 1.0 mg of preservative free morphine was injected and determined to be a good starting dose for her. Details on her progress and treatment after January 1991 were not provided.

Accusation Allegations – Patient J.W.

[Gross Negligence, Repeat Negligence, Incompetence]

44. *Second Supp. Accusation Paragraphs 18A-E* – Complainant alleges that Respondent failed to perform a complete history and physical, did not initiate a treatment plan, and by not having same could not evaluate the

patient at periodic intervals using the original history and physical as a baseline.

Respondent's history and physical examination were adequate for the intended purpose. (Exhibit FF) A treatment plan had been formulated by Respondent and J.W. was evaluated at periodic intervals. These Accusation allegations were not established.

45. *Second Supp. Accusation Paragraph 18F* – Complainant alleges that Respondent failed to use other medications or treatment modalities commonly used by pain management physicians.

It was noted in J.W.'s history (Exhibit FF) that she had already received a trial of medications and other treatment modalities. She had been to two other pain clinics and a neurologist, and she had also received psychological counseling. Other treatments recommended by Dr. Levin were not on the market at that time (eg. Capsaicin cream and selective serotonin re-uptake inhibitors). Adjunctive therapies and medications were used by Respondent. These allegations were not established.

46. *Second Supp. Accusation Paragraph 18G* – Complainant alleges that Respondent incompetently, negligently or grossly negligently taught, encouraged and/or allowed J.W. to self-administer narcotics on an as needed basis, in the epidural and intrathecal catheters.

Allowing patients to self-inject narcotics via catheter epidurally has already been discussed (Finding 17) and determined to be an extreme departure from the standard of care because of the risks associated with same. The same would also be true of catheters placed intrathecally

(subarachnoid). Allowing patients to self-inject entails a high risk of infection in the epidural or intrathecal space, which can lead to permanent neurological damage or death. Though the risk is well recognized and permitted for terminal cancer patients, it is not acceptable for non-cancer patients.

Respondent's practice in allowing J.W. to self-inject narcotics was an extreme departure from the standard of care.

47. *Second Supp. Accusation Paragraph 18H* – Complainant alleges that Respondent incompetently, negligently or grossly negligently used deposteroids in the epidural space. This practice has already been discussed (Finding 37) and is determined to be appropriate. It is also supported by medical literature submitted by Respondent. It is acceptable to start a trial of epidural steroids and then abandon it if found as here to be ineffective. This allegation was not sustained.

48. *Second Supp. Accusation Paragraph 18I* – Complainant alleges that Respondent continued to repeat epidural or sympathetic nerve blocks in spite of the fact that J.W. exhibited no sustained response to same. It is argued that Respondent should have known that if the injections were continued, each injection should have provided a more long lasting pain relief period. And that if this did not occur the patient is not responding to the nerve blocks and they should be abandoned, or a neurolytic block performed.

When J.W. was first seen she had a series of sympathetic blocks with some slight but apparent improvement. Her treatment was interrupted, and when she returned

her pain was back at baseline. The series was repeated until it became apparent that she was not going to respond with continued improvement. No further blocks were performed at that point and a neurolytic block was in fact recommended. (See Exhibit 74 letter, p. 181.) J.W. was advised against the neurolytic block and she opted instead for a surgical sympathicectomy which was performed at Stanford University. For these reasons the Accusation allegations were not sustained.

49. *Second Supp. Accusation Paragraph 18J* – Complainant alleges that Respondent prescribed numerous narcotics without evaluating the patient's response other than her subjective report of pain relief. It is argued that J.W. continued to rapidly escalate the dose and not keep detailed accounts of the medication that she was using. And that without any objective improvement in her pain, and with the massive escalation in narcotic usage from Damason P to methadone and Roxanol, the continuing use of these narcotics was contraindicated.

Respondent's notes on J.W. document functional improvement along with subjective reports of diminished pain. J.W. had pain in her knee to such an extent that she underwent a fusion operation. It is not clear what other objective measures of improvement were expected by Dr. Levin. J.W. was an intractable pain patient, and it was appropriate for Respondent to be guided by her subjective reports of pain in managing her care and treatment.

50. *Second Supp. Accusation Paragraph 18K* – Complainant alleges that Respondent failed to investigate other specific treatments which may have been effective for J.W. In support, it is noted that once intravenous

Reserpine was determined to provide relief for up to one week, this procedure should have been repeated instead of epidural injections. The latter were providing shorter term relief and are considered to be more invasive and destructive therapies. Similarly, it is suggested that Respondent should have tried spinal cord stimulation which is routinely used for reflex sympathetic dystrophy and is considered safer, more reliable, less costly and more effective than narcotics alone.

Respondent did not pursue intravenous Reserpine therapy because it had been removed from the market at that time, and those who retained supplies in their office used same only sparingly. Respondent did discuss spinal cord stimulation with her and after she left his care she actually went on trial stimulation therapy with poor results. In fact, a number of therapies including block therapy, neurolytic blocks, IV block, oral medications and stimulation had all been discussed with her by Respondent. This Accusation allegation was not sustained.

51. *Second Supp. Accusation Paragraph 18L* – Complainant alleges that Respondent incompetently, negligently or grossly negligently continued to repeatedly place temporary, as well as "permanent," epidural catheters, despite mechanical problems with the catheters and despite the fact that J.W. never had any evidence of sustained pain relief with the catheters. It is also alleged that he inserted the catheters in an non-sterile environment. The standard urged is that such be placed in surgery centers, and with standards in place for peer review or input.

There was no evidence that Respondent placed the catheters in a non-sterile environment. It is clearly standard of care to do these procedures with sterile technique and in sterile surroundings. In the absence of any evidence that Respondent did otherwise, this charge cannot be sustained. As far as the repeat placements, Respondent notes that the reason the catheters needed to be repeatedly replaced is exactly because J.W. did not get sustained relief and because there were mechanical problems. Technical problems with the catheter's placement are no reason to discontinue that therapy. When properly placed, J.W. did obtain pain relief. This allegation was not sustained.

52. *Second Supp. Accusation Paragraph 18M* – The matter of patient observation over 24 hours after epidural or intrathecal narcotic injection was discussed in Finding 37. Dr. Levin acknowledges that Respondent's practice is now considered appropriate.

53. *Second Supp. Accusation Paragraph 18N* – Complainant alleges that on the final visit to Respondent's office, he performed a spinal puncture on J.W. to inject morphine for evaluation of a starting dose for intrathecal narcotic infusion if a pump were placed, and that such injection had no clear indication and was therefore clearly excessive use of a diagnostic procedure.

Respondent's medical objective was clear. He wanted to determine what starting dose would be appropriate. This was not merely a repeat of an earlier diagnostic procedure. As such, Respondent's actions were reasonable and not without medical indication. This allegation was not sustained.

54. . *Second Supp. Accusation Paragraph 19* – The general allegations covering the period of J.W.'s treatment by Respondent are covered in Findings 44 through 53.

55. *Second Supp. Accusation Paragraph 20* – Complainant alleges that on the visit when Respondent administered an injection of morphine for evaluation of a starting dose for intrathecal narcotic infusion pump purposes, such constituted repeated acts of clearly excessive prescribing or use of treatments. By reason of the matters set forth in Finding 53, this allegation cannot be sustained.

Seventh Cause For Disciplinary Action

56. *Treatment History – Patient A.C.*

a. Patient A.C. was first seen by Respondent on November 30, 1987. The then 34 year old female complained of lower back pain, muscle spasm from shoulder blades to tailbone, and sporadic pain down through buttocks to lateral aspect of both thighs. The pain had persisted over three months from the time of her having an individual fall on her while she was in a squatting position. Her original diagnosis was lumbar strain and she was treated conservatively with rest and anti-inflammatories by another physician. Studies were negative for any acute processes or disc herniation, but degenerative changes (desiccation) were noted in the L1/2 and L5/S1 discs on a magnetic resonance imaging (MRI) scan. She was eventually referred to Respondent by John Knight, M.D. for management of her muscle spasms and back pain. She was already on a regimen of Vicodin, 1-2 as

needed for pain, Soma 1 every four hours and Feldene, 1 every morning.

b. Respondent took a complete history and performed a physical examination. His diagnostic impression was that she had persistent ligamentous strain of the lumbar spine and possibly a problem in her sacroiliac joint contributing to her pain. Respondent was told that she had previously received an epidural steroid injection, but not being satisfied that it was reported accurately to him, he determined to repeat the procedure himself. His plan was to do a differential epidural block with epidural steroids and probably narcotics to try to separate the back from the sacroiliac component; and depending upon the results, to refer her for manual therapy techniques. On this first visit an epidural injection was attempted with incremental 0.5% Lidocaine and 10 cc of 2% Nesacaine. A.C. reacted adversely with central nervous system (CNS) irritability with some twitching, hypertension and tachycardia. Respondent noted no loss of consciousness, although A.C. believes that she passed out at the time. Respondent suspected that the catheter had migrated into a blood vessel and planned to attempt the procedure again the following day.

c. On December 1, 1987, Respondent repeated the differential epidural injection with incremental 0.5% Lidocaine. After about an hour and 200 mg total medication, she again had a CNS reaction with loss of consciousness. She was given two incremental 5 mg Valium injections IV and her level of consciousness returned after 30 to 45 minutes. Respondent completed the diagnostic block and determined that her continuing pain indicated that there was little or no sympathetic component. He subsequently

injected DepoMedrol 80 mg, followed with 50 mg of Demerol. She experienced substantial pain relief and rested comfortably before leaving the office.

d. On December 3, 1987, Respondent injected 5 mg of morphine via midlumbar epidural catheter. After a half hour, Respondent injected another 5 mg of morphine, which provided her only partial pain relief. Believing that a small amount of Lidocaine would provide a little somatic block without any risk of repeating previous CNS symptoms, he injected 5 cc of 1% Lidocaine. She experienced involuntary twitching, but no loss or change of consciousness. She also developed marked itching and nausea which he related to the morphine injection, and for which she was given Narcan. Out of concern for her CNS reaction to epidural Nesacaine and Lidocaine, Respondent referred A.C. to Robert Sternbach, M.D. for a neurology consultation. On January 22, 1988, Dr. Sternbach opined that it was unlikely that she would experience seizures or loss of motor control outside the epidural injections, notwithstanding his never having seen such a reaction in response to epidural anesthetics. Respondent had already determined not to use any Lidocaine beyond that used to numb her for the injection itself. And he planned to pursue other approaches including a weight loss program, spinal examination by Dr. Dahlis Day and psychological counseling and/or hypnosis to help modify her perceptions of pain.

e. On December 10 Respondent injected 10 mg of morphine via midlumbar epidural catheter with mild CNS effects for which she received 0.4 mg Narcan. On December 11 she was injected with a total of 20 mg

morphine in the mid-upper lumbar epidural space, from which she reported good, long lasting relief.

f. On December 14, she received 10 mg morphine via catheter, which was then removed. A second 10 mg injection of 10 mg morphine followed through a single shot epidural technique. Some nausea was treated with a Narcan injection. Later that day, A.C. passed out in her office parking lot and was taken by strangers to John Muir Medical Center where she was hospitalized until December 16 for observation after excessive epidural morphine. Her admission symptoms included vomiting, rash, itching and bladder distention. Respondent was not aware of this incident until after the fact.

g. On December 21, Respondent removed the catheter and started A.C. on methadone 5 mg pills to see if she might receive better relief than from the Vicodin she was taking. He instructed her to titrate the dose with follow up visits; and to also begin a course of physical therapy, psychological counseling and techniques for modification of pain perception.

h. Between January and March 1988, A.C. tried various other methods of pain management including physical therapy, supportive counseling and self-hypnosis. In addition to taking methadone 10 mg every four hours for pain, she was also prescribed Vistaril for anxiety, Soma as muscle relaxant and Deseryl 50 mg before sleeping as an anti-depressant medication. She reported getting very poor relief with the methadone and other modalities and on April 5, 1988, indicated that she would like to try epidural morphine again.

i. Respondent injected her on April 5 with 5 mg morphine via upper lumbar epidural catheter, followed by a second injection in that same amount. She had transient CNS symptoms with complaints of light-headedness and mild twitching. She reported that she was feeling better and getting good relief. Her 14 year old son was given some Narcan in a syringe in the event she had a problem. Respondent merely makes reference to her "attendant" being given the Narcan in a syringe.

j. On April 6, 1988, Respondent injected her epidurally with 15 mg of morphine. He also taught her self-injection techniques, and continued such instruction over the next two office visits on April 7 and 8, when Respondent had her draw up and administer morphine 15 mg to herself. He was satisfied that she demonstrated "very skilled technique" in drawing and giving morphine.

k. On April 11, A.C. reported 12-14 hours pain relief with self-injections of 15 mg morphine/day. However, she had developed a low grade fever, tenderness around the catheter site with a purulent discharge. Respondent cleansed the site with peroxide and betadine, with the expectation that her son would continue this wash four times daily. He also prescribed the antibiotic Dicloxicillin 500 mg four times daily. He explained to her the concerns of further infection if not brought under control and noted that A.C. "was quite emphatic that she did not want the catheter removed, if at all possible."

l. On April 13, the tenderness around the catheter site had gone away. She had started giving herself a second injection at night, in a smaller amount, and reported receiving excellent relief. The progress report for

that date does not indicate the amount of morphine she was self-injecting daily, and concludes by noting that Respondent would follow up on an as needed basis.

m. On April 18, A.C. had a temperature of 100 degrees, with localized erythema/minimal tenderness, although Respondent opined that it was not evidence of epidural infection. He planned to pull the catheter if it was a systemic infection, and his plan was to rule out same. On April 25, tenderness was again noted around the catheter site, her temperature was elevated, catheter injections were less effective and she complained of a headache. Respondent pulled the catheter and planned to use methadone during the interim until her temperature was back to normal. On April 27, a DuPen long term epidural catheter was placed in A.C. at approximately the L1-2 interspace.

n. The pertinent history of medical care and treatment between May 5 and September 6, 1988 is summarized in the Second Supplemental Accusation, paragraph 39 and is set forth below with minor changes:

> **May 5, 1988** – The catheter was not working well and it was thought to be disconnected. X-ray with dye showed the catheter to be in the epidural space and the patient was injected with 15 mg of morphine.
>
> **May 12, 1988** – The patient complained of poor pain relief and nausea following larger doses, without any notation of how much narcotic was being used or given. Respondent assessed probable CNS effects of morphine sulfate and planned a Narcan trial but with no notation of how much would be given her.

May 20, 1988 – Injections do not give relief and fluid was observed coming out at the catheter site. The DuPen catheter was replaced in Respondent's office.

May 27, 1988 – Visit for suture removal. Patient noted to have lost 15 pounds in one week. Chart notes that there would be a follow-up when A.C. has lost another 20 pounds.

June 8, 1988 – Catheter stopped working the day before with fluids coming out with injections. In his office, Respondent removed the distal portion of the catheter and saved it. The same internal part of the catheter system was then reused and a new external part attached.

June 9, 1988 – A catheter connector failure was noted due to separation at the point where the internal and external catheters connect. The connection was repaired in Respondent's office.

June 17, 1988 – Injectate completely leaking out of catheter site with poor pain relief. The patient felt like she was in withdrawal. The catheter was injected with 15 mg morphine while in the sitting position with no leakage.

July 25, 1988 – A.C. complained that the catheter had been very painful to inject. There was some erythema at the skin site. She continued to lose weight, approximately 35 pounds to date. She was started on a trial of antibiotics.

August 1, 1988 – There was leakage at the catheter site again. The catheter was revised, in office, again using the same internal part which was reinserted.

August 8, 1988 – The catheter continued to leak. It was injected with fluid and air. Fluid leaked

back easily and air bubbles were felt distal to the catheter connection site, although X-ray showed the catheter to be in good position. Respondent performed a replacement procedure of the epidural portion of the DuPen long term epidural catheter. He inserted a new 20 gauge-nylon epidural catheter and secured same to the existing DuPen catheter.

August 15, 1988 – A.C. complained of pain upon injection but she was obtaining good pain relief. Respondent injected a small amount of Depomedrol (20 mg) as trial for a possible non-specific inflammation. The injection was not for the purpose of trying to keep the catheter open.

August 24, 1988 – A.C. reported excellent results from the steroid injection of August 15, reducing pain with injection and lasting almost ten days. She requested a repeat injection and Respondent injected DepoMedrol (20 mg).

September 6, 1988 – A.C. reported injections were becoming very painful for her again. She got good improvement in these symptoms for several weeks after injection of steroids and desired to repeat same. Respondent injected DepoMedrol (20 mg). He noted that she continued to lose weight and that her problem may have been catheter migration which would have to be moved if she continued to have problems.

o. On September 9, 1988, A.C. was seen in the emergency room of Mt. Diablo Hospital with complaints of shortness of breath, coughing and wheezing following self-injection of morphine epidurally. She had a history of three to four weeks of mild episodes of "wheezing" after injection. She was given Alupent 0.3 cc and observed for

an hour until her symptoms resolved. She was discharged with Benadryl 50 mg every six hours, and instructed to hold morphine injections and to follow up with Respondent. Respondent does not believe her described symptoms related at all to the morphine injections, but represented instead an anxiety reaction.

p. A.C. saw Respondent on September 21 with complaints of pain upon injection, requiring her to inject herself over a two hour period. Respondent found no evidence of infection. He injected her with 20 mg DepoMedrol.

q. On October 5, 1988, A.C. complained of mild difficulty breathing after her injections which was relieved with antihistamines. She also complained of painful injections. Respondent injected Demerol epidurally, without recording the dosage. That evening she was seen in the emergency room of Los Medanos Community Hospital with complaints of severe back pain radiating to her left hip. A.C. reported a history of catheter migration and was given Valium intravenously, and injected with Lidocaine epidurally before being discharged home ambulatory. She saw Respondent the following day.

r. On October 6, 1988, Respondent determined that she likely had an epidural infection, but not an abscess. The epidural portion of the DuPen catheter was removed, and the tip placed in a sterile container for gram stain and culture. She was then transported to Los Medanos Community Hospital where she was admitted with tenderness at the catheter site, an elevated white blood cell count (11,000 on admission), low grade temperature. The

plan was to determine if the infection was superficial or parameningeal. Meningitis was ruled out. She was placed on antibiotic therapy and discharged on October 13 with a diagnosis of cellulitis at the site of the epidural catheter, chronic back pain and chronic narcotic use. Her discharge medications included methadone, 10 mg, three every four hours for pain.

s. On October 17, 1988, Respondent saw A.C. and noted that her pain was under partial control with 30 mg methadone every four hours. He was concerned about further sedation and slow mentation as drug effects, and prescribed 5 mg amphetamine twice daily to minimize the side effects.

t. On November 2, 1988, Respondent removed the external portion of the DuPen catheter. He noted that her pain relief was not very good with oral medications. He also discussed with her the possibility of surgery (lumbar spine fusion) with Dr. Barnes after further weight reduction on her part.

u. On November 29, 1988, A.C. reported that her methadone had not been working well for her over the preceding two weeks. He recommended that she increase her narcotic intake to 3-4 pills every four hours, and not the 2-3 that she had been taking.

v. On December 13, 1988, Respondent refilled her medication prescriptions. Thereafter, over the next twelve months, A.C. was seen at the Pain Relief Center in Walnut Creek principally by Respondent's wife, Dahlis M. Day, M.D. She attempted with limited success to taper A.C. off methadone, starting with one less tablet per day per week.

Accusation Allegations – Patient A.C.

57. *Second Supp. Accusation Paragraph 49A-C* – Complainant alleges that Respondent failed to record an adequate history or to perform a complete physical examination, did not initiate a treatment plan noting what objective features would be used to evaluate the success of the treatment, and therefore could not evaluate the patient at periodic intervals using the original history and physical as a baseline. Board medical expert John H. Eisele Jr., M.D. has retracted these criticisms after being show [sic] pertinent medical records at hearing. These allegations were not sustained.

Respondent's initial visit with A.C. is also criticized for his performing a differential epidural injection of steroids and local anesthetic to separate the back from the sacroiliac component of her pain. Dr. Eisele believes that the appropriate procedure would be to plan a sacroiliac joint injection to determine if that was the source of pain, or to perform an epidural steroid injection to assess its effect on her back. Respondent opines that the sacroiliac joint is not an easy joint to identify and to inject, with a relatively low success rate. He also believes that it is possible to separate out the sympathetic and somatic components of pain via his differential epidural injection. It was not established that his approach was outside the standard of care.

Respondent is also criticized for failing to aspirate before injecting epidural Lidocaine and Nesacaine. While it is true that his records do not reflect whether he aspirated, such is his usual habit and routine. He cannot be faulted for failing to record so basic a procedure. This

also assumes that the catheter was placed in an epidural vein. Because her adverse reaction may have been psychologic, she was also referred to a neurologist for evaluation. It was not established that Respondent failed to aspirate before injecting epidural anesthetics.

58. *Second Supp. Accusation Paragraph 49D* – Complainant alleges that Respondent's injecting a narcotic (Demerol) into the epidural space at the same time as the steroids (DepoMedrol) only confused the pain assessment. The manner of Respondent's use of differential epidural blocks has been discussed. (Finding 30) The effects of Demerol would be known within six hours, and the effects of the steroid would be able to be assessed over 24 to 48 hours. It was a rational attempt to assess both drugs in an effort to find a long term solution to A.C.'s pain. This allegation was not sustained.

59. *Second Supp. Accusation Paragraph 49E* – Complainant alleges that Respondent failed to arrange for observation of A.C. over the 24 period after injection with epidural morphine. It is also alleged that his subsequent injection of epidural Lidocaine in a patient known to have adverse reactions to epidural local anesthetics was strongly contraindicated. Respondent's practice re observation of patients has been discussed in Findings 37 and 52. Sending patients home after epidural narcotics is now accepted without the more prolonged observation period.

Respondent opines that all documented instances of allergic reactions to Lidocaine are actually due to preservatives in multiple dose vials or to toxic reactions from IV injection or overdose. Respondent injected Lidocaine that was preservative free. He took appropriate measures by

referring her to a neurologist. He also involved her internist early on in his treatment. This allegation was not sustained.

60. *Second Supp. Accusation Paragraph 49F* – Complainant alleges that Respondent incompetently, negligently or grossly negligently allowed A.C. to self-administer morphine and, later, oral methadone, on an as needed basis. The issue of prescribing methadone on an as needed basis was found to be appropriate in certain cases where the outer parameters are defined (Finding 25) and such is the case here. The issue of self-injection will be addressed in Finding 61.

Complainant alleges further that Respondent proceeded to prescribe powerful narcotics before ruling out other available treatment modalities first. Respondent was aware that A.C. had already been to two other physicians and had several trials of other therapies (Finding 56a). It is appropriate for a pain treatment specialist to start a patient on narcotics if believed to be useful and attempts to treat the pain have been made by other physicians. This allegation was not sustained.

It is also alleged that A.C. had become addicted and that she was the one in control of the narcotics and that Respondent had abdicated and lost total control of the situation to the point where he no longer knew how much morphine she was self-injecting. Board medical expert Dr. Eisele does not assert that A.C. became an addict. These allegations were not proven.

61. *Second Supp. Accusation Paragraph 49G* – Complainant alleges that Respondent incompetently, negligently or grossly negligently taught, encouraged and/or

allowed A.C. to self-administer narcotics, on an as needed basis, in the epidural and intrathecal catheters.

The issue of self-injection has already been discussed and determined to be an extreme departure from the standard of care. (Findings 17 and 46) Twice A.C. was seen in the emergency room for adverse reactions to self-injected narcotics. Once she had to be hospitalized for an infection at the site of the catheter itself. Patient self-injection entails a high risk of infection in the epidural or intrathecal space. Trained medical personnel are in a better position to monitor such risks and to respond to any adverse patient reactions such as those experienced by A.C.

62. Second Supplemental Accusation Paragraphs 49H and 49J were dismissed by Complainant.

63. *Second Supp. Accusation Paragraph 49I* – Complainant alleges that Respondent incompetently, negligently and/or grossly negligently performed procedures numerous times in a technically inadequate fashion, in an environment that was not aseptic and without use of a surgery center where these procedures are typically done.

It is argued that Respondent should have status as a licensed surgery center before such procedures can be performed in his office. There is no such legal requirement. It is also alleged that Respondent should have implanted a narcotic infusion pump and spinal catheter which would have enabled him to exercise reasonable charge of the amount of narcotic to be administered and at the same time provide a totally enclosed (beneath the skin), aseptic system.

The matter of a sterile environment has already been discussed (Finding 51). Respondent notes that most procedures are traditionally performed in surgery centers or hospitals only because most anesthesiologists are located there, and not in clinical settings such as his. While an infusion pump clearly has certain advantages, Respondent believed his care for A.C. was to be transient and in anticipation of future discogram and surgery. Viewed in that context, an infusion pump was seen as unnecessarily expensive and something that would be difficult to have insurance carriers underwrite. This allegation was not sustained.

64. *Second Supp. Accusation Paragraph 49K* – Complainant alleges that Respondent continued to prescribe numerous narcotics without evaluating A.C.'s response other than her subjective report of pain relief. And that without any objective improvement in her pain, the continuing use of these narcotics was contraindicated. A.C. assumed inappropriate control of her treatment regimen to the point that an epidural catheter be left in place despite a low grade fever and tenderness at the epidural catheter site.

It is appropriate to rely upon patient subjective reports of pain as a basis for treatment. The matter of leaving the epidural catheter in place was discussed with A.C. and she requested that it be left in place "if at all possible." This was not a refusal to have it removed, and was consistent with allowing patient participation in making treatment decisions.

It is further alleged that Respondent allowed A.C.'s minor son to be responsible for administering Narcan in a

syringe to her if needed. This was an extreme departure from the standard of care. Teaching her minor son to assist her in injecting the narcotic antagonist narcan, if necessary, constituted gross negligence.

65. *Second Supp. Accusation Paragraph 49L* – It is alleged that Respondent caused A.C. to undergo, without medical indication or justification, numerous epidural anesthetics with local anesthetic and narcotics. These procedures are argued to be without any diagnostic or therapeutic value and to constitute clearly excessive use of diagnostic and/or treatment procedures.

Respondent avers that all blocks were performed in good faith and medically indicated for diagnostic or therapeutic purposes. This was supported by the medical record. The allegation was not sustained.

66. *Second Supp. Accusation Paragraph 50* – The general allegations covering the period of A.C.'s treatment by Respondent are covered in Findings 57 through 65.

67. *Second Supp. Accusation Paragraph 51* – It is finally alleged that the treatment provided to A.C. constitutes repeated acts of clearly excessive use of diagnostic treatment procedures (spinal anesthetics via epidural catheters) as determined by the standard of community of licensees. For reasons already discussed in Finding 65, this allegation was not sustained.

Other Matters

68. *Certification of Costs* – The costs of prosecution charged by the Department of Justice, Health Quality Enforcement Section and incurred by the Medical Board

in this case through fiscal year 1995-96 are $3,544.50 for legal analyst time and $71,870.00 for attorney time. (Exhibit 106)

69. Respondent has very strong philosophical beliefs about the management of patients with chronic, non-malignant pain. His background in anesthesiology predisposes him to address and ameliorate pain symptoms directly, whereas other specialists might first seek out the etiology underlying pain. Most patients when first seen by Respondent had already been treated by primary physicians for underlying conditions, and then went to Respondent specifically for management of their chronic pain.

Although therapeutic measures were taken to bring about complete healing and relief of pain symptoms, Respondent also viewed reduction of pain as an end in itself, even in the absence of improved function or healing. He believed what patients said about their pain and was guided by their subjective statements unless he had evidence to the contrary. Such trust was derived from basic ethical principles he observed and which defined his duty to patients. These included allowing patients the right to self-determine when they need analgesia to guarantee client autonomy. He believes patients have the right to make choices in collaboration with caregivers regarding treatment modalities. He strongly believes that "[p]aternalism is the antithesis of autonomy in health care."

Citing to an article detailing an ethical model for pain management practitioners Respondent notes:

> "It is very apparent that ethics pervade every aspect of pain management, . . . These care recipients expect and demand pain relief in short order. There is an inherent obligation for the practitioner in any setting to be nonjudgmental and respectful of others rights, values and beliefs. This obligation is tested to the limit for those working with patients suffering acute and/or chronic pain."

(See Exhibit KK, p. 6; Greipp, *An Ethical Model for Pain Management Practitioners*. American Journal of Pain Medicine; Volume 3, 1993.)

70. Given the above, Respondent's approach to management of pain has typically been very aggressive and dynamic. He has availed himself of conservative modalities, but was also quick to incorporate more aggressive approaches when he believed them to be more effective in achieving pain relief. Where such approaches have been determined to be outside the standard of care (e.g., self-injection epidurally) he can certainly make adjustments to change such practices. Changes in his practice will likely occur in those areas where practice standards are more clearly defined, as this decision has attempted.

There are important distinctions that need to be made in his thinking, especially those between management of chronic non-malignant pain and management of terminal cancer pain. Progress in the management of pain in chronic pain patients, particularly the use of controlled substances, has largely built upon experience in the field of cancer pain management. But the door was never opened wide to making the full armamentarium of cancer

pain interventions the standard of care for treating patients with chronic non-malignant pain. Respondent should now understand this and, more importantly, accept the limitations imposed upon his use of the more dangerous interventions in addressing pain. This is especially true where such interventions require more physician monitoring and less patient control.

Respondent presents as a physician who will conform his practice to well defined medical practice standards. His strong and spirited defense of his actions were largely based upon good faith differences with Board medical expert witnesses. Complainant's assertions notwithstanding, Respondent does not appear to be so stubborn or ego driven that he cannot fathom and then make the appropriate changes in his medical practice. Such changes can be confirmed by oral examination, interviews and Board monitoring of his medical practice over a reasonable period of probation.

For all the above reasons, it would not be contrary to the public health, safety or welfare to issue Respondent a probationary license at this time.

DETERMINATION OF ISSUES

Patient M.O.

1. *Accusation paragraph 28E*: Cause for disciplinary action exists under Business and Professions Code section 2234 (b), (c) and (d), by reason of the matters set forth in Finding 17. Respondent's conduct in allowing patient M.O. to self-inject opiate medications through an epidural catheter constituted negligence, gross negligence and incompetence.

2. *Accusation paragraphs 28A-D, F, G; 29 and 30*: No cause for disciplinary action exists under Business and Professions Code sections 2234 and 725, by reason of the matters set forth in Findings 14-16, and 18-21. Clear and convincing evidence to a reasonable certainty was not presented in support of these allegations.

Patient M.G.

3. *First Supp. Accusation paragraphs 12A-E*: Cause for disciplinary action exists under Business and Professions Code section 2234(c), by reason of the matters set forth in Finding 23. Respondent's failure to perform an adequate history and physical examination, to develop a specific treatment plan and to perform thorough evaluations upon return visits constituted repeated acts of negligence.

4. *First Supp. Accusation paragraphs 12F-G; 13, 14:* No cause for disciplinary action exists under Business and Professions Code sections 2234 and 725, by reason of the matters set forth in Findings 24 through 27. Clear and convincing evidence to a reasonable certainty was not presented in support of these allegations.

Patient M.H.

5. *First Supp. Accusation paragraph 26A/B*: Cause for disciplinary action exists under Business and Professions Code section 2234(c), by reason of the matters set forth in Finding 29. Respondent negligently allowed Patient M.H. to self-administer methadone on an as needed basis at a time when her psychological and drug history dictated otherwise.

6. *First Supp. Accusation paragraphs 26C, 27 and 28:* No cause for disciplinary action exists under Business and Professions Code sections 2234 and 725, by reason of the matters set forth in Findings 30 through 32. These allegations were not supported by clear and convincing evidence to a reasonable certainty.

Patient B.C.

7. *First Supp. Accusation paragraph 45K/L:* Cause for disciplinary action exists under Business and Professions Code section 2234 (a) and (b), by reason of the matters set forth in Finding 40. Respondent's decision to place the infusion catheter at the thoracic level under general anesthesia with no fluoroscopy constituted gross negligence and incompetence.

8. *First Supp. Accusation paragraphs 45A-J, 46, 47:* Except as noted in Determination VII, no cause for disciplinary action exists under Business and Professions Code sections 2234 and 725, by reason of the matters set forth in Findings 34-39, 41 and 42. These allegations were not supported by clear and convincing evidence to a reasonable certainty.

Patient J.W.

9. *Second Supp. Accusation paragraph 18G:* Cause for disciplinary action exists under Business and Professions Code section 2234(b), (c) and (d), by reason of the matters set forth in Finding 46. Respondent's practice in allowing J.W. to self-inject narcotics constituted repeated acts of negligence, gross negligence and incompetence.

10. *Second Supp. Accusation paragraphs 18A-F, H-N, 19-20*: Except as noted in Determination IX, no cause for disciplinary action exists under Business and Professions Code sections 2234 and 725, by reason of the matters set forth in Findings 44-45, and 47-55. These allegations were not supported by clear and convincing evidence to a reasonable certainty.

Patient A.C.

11. *Second Supp. Accusation paragraph 49G*: Cause for disciplinary action exists under Business and Professions Code section 2234(b), (c) and (d), by reason of the matters set forth in Finding 61. Respondent's practice in allowing A.C. to self-inject narcotics on an as needed basis constituted repeated acts of negligence, gross negligence and incompetence.

12. *Second Supp. Accusation paragraph 49K*: Cause for disciplinary action exists under Business and Professions Code section 2234(b), by reason of the matters set forth in Finding 64. Respondent's conduct in allowing A.C.'s minor son to provide her Narcan constituted gross negligence.

13. *Second Supp. Accus. paragraphs 49A-J, L; 50, 51*: No cause for disciplinary action exists under Business and Professions Code sections 2234 and 725, by reason of the matters set forth in Findings 57-63, and 65-67. These allegations were not supported by clear and convincing evidence to a reasonable certainty.

Other Matters

14. The Board is entitled to recover the reasonable costs it has incurred in the investigation and prosecution of this case under Business and Professions Code section 125.3. Although these charges reflect the reasonable and necessary work performed on this case, a majority of the allegations investigated and prosecuted before the Board were not sustained. Under these circumstances, some apportionment of costs is appropriate. (*Hensley v. Eckerhart* (1983) 461 U.S. 424.)

Accordingly, Complainant should be ordered to prepare a new cost statement which reasonably approximates the percentage of Department of Justice time devoted to the investigation and prosecution of those allegations which were sustained. This should be submitted to Dr. Day and to the administrative law judge for review and consideration in making a further order for cost recovery under Business and Professions Code section 125.3. In the alternative, the parties may on their own reach agreement on such sum and provide for payment of same as part of the Board's final decision in this case.

By reason of the matters set forth in Finding 68, such costs should be apportioned and a decision on the amount of costs deferred until further information is provided by the Department of Justice as specified.

15. The matters set forth in Findings 69 and 70 were considered in making the following order. It would not be contrary to the public interest to issue Respondent a probationary license at this time.

ORDER

Certificate No. G-39260 issued to Respondent Franklin Jerome Day, M.D. is revoked pursuant to Determination of Issues 1, 3, 5, 7, 9, 11 and 12; separately and for all of them. However, revocation is stayed and Respondent is placed on probation for five years upon the following terms and conditions. Within 15 days after the effective date of this decision Respondent shall provide the Division, or its designee, proof of service that Respondent has served a true copy of this decision on the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent or where Respondent is employed to practice medicine and on the Chief Executive Officer at every insurance carrier where malpractice insurance coverage is extended to Respondent.

1. Respondent shall obey all federal, state and local laws, all rules governing the practice of Medicine in California, and remain in full compliance with any court ordered criminal probation, payments and other orders.

2. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation.

3. Respondent shall comply with the Division's probation surveillance program. Respondent shall, at all times, keep the Division informed of his addresses of business and residence which shall both serve as addresses of record. Changes of such

addresses shall be immediately communicated in writing to the Division. Under no circumstances shall a post office box serve as an address of record. Respondent shall also immediately inform the Division, in writing, of any travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) days.

4. Respondent shall appear in person for interviews with the Division, its designee or its designated physician(s) upon request at various intervals and with reasonable notice.

5. In the event Respondent should leave California to reside or to practice outside the State or for any reason should Respondent stop practicing medicine in California, Respondent shall notify the Division or its designee in writing within ten days of the dates of departure and return or the dates of non-practice within California. Non-practice is defined as any period of time exceeding thirty days in which Respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code. All time spent in an intensive training program approved by the Division or its designee shall be considered as time spent in the practice of medicine. Periods of temporary or permanent residence or practice outside California or of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary period.

6. Respondent shall take and pass an oral clinical exam in a subject to be designated and administered by the Division, or its designee. This examination shall be taken within 90 days after the effective date of this decision. If Respondent fails the first examination, Respondent shall be allowed to take and pass a second examination, which may consist of written as well as an oral examination. The waiting period between the first and second examinations shall be at least three months. If Respondent fails to pass the first and second examinations, Respondent may take a third and final examination after waiting a period of one year. Failure to pass the oral clinical examination within 18 months after the effective date of this decision shall constitute a violation of probation. Respondent shall pay the costs of all examinations.

   Respondent shall not practice medicine until Respondent has passed the required examination and has been so notified by the Division or its designee in writing. This prohibition shall not bar Respondent from practicing in a clinical training program approved by the Division, or its designee. Respondent's practice of medicine shall be restricted only to that which is required by the approved training program.

7. Within 90 days of the effective date of this decision, and on an annual basis thereafter, Respondent shall submit to the Division or its designee for its prior approval an educational program or course to be designated by the Division, which shall not be less

than 40 hours per year, for each year of probation. This program shall be in addition to the continuing Medical Education requirements for re-licensure. Following the completion of each course, the Division or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of continuing medical education of which 40 hours were in satisfaction of this condition and were approved in advance by the Division or its designee.

8. Within 30 days of the effective date of this decision, Respondent shall submit to the Division or its designee for its prior approval a plan of practice in which Respondent's practice shall be monitored by another physician in Respondent's field of practice, who shall provide periodic reports to the Division or its designee. If the monitor resigns or is no longer available, Respondent shall, within 15 days, move to have a new monitor appointed, through nomination by Respondent and approval by the Division or its designee.

9. Respondent shall pay the costs associated with probation monitoring each and every year of probation. Such costs shall be payable to the Division of Medical Quality and delivered to the designated probation surveillance monitor at the beginning of each calendar year. Failure to pay costs within 30 days of the due date shall constitute a violation of probation.

10. Upon successful completion of probation, Respondent's certificate shall be fully restored.

11. If Respondent violates probation in any respect, the Division, after giving Respondent notice and an opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an accusation or petition to revoke probation is filed against Respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

12. The matter of cost recovery shall be deferred until further consideration of apportionment is undertaken per Determination 14 and further order issued.

13. Following the effective date of this decision, if Respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may voluntarily tender his certificate to the Board. The Division reserves the right to evaluate Respondent's request and to exercise its discretion whether to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the tendered license, Respondent will no

longer be subject to the terms and conditions of probation.

DATED: July 18, 1996

/s/ Jonathan Lew
JONATHAN LEW
Administrative Law Judge
Office of Administrative Hearings

CONSTITUTIONAL, STATUTORY and REGULATORY PROVISIONS INVOLVED

Constitution

U.S. Const., Art I, * 8, Cl.14. " . . . The Congress shall have Power . . . To make Rules for the Government and Regulation of the land and naval Forces."

U.S. Const., 14th Amendment, * 1, "All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the state wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws."

Federal Rules

Fed.R.Civ.P. 63: "If a trial or hearing has been commenced and the judge is unable to proceed, any other judge may proceed with it upon certifying familiarity with the record and determining that the proceedings in the case may be completed without prejudice to the parties. In a hearing or trial without a jury, the successor judge shall at the request of a party recall any witness whose testimony is material and disputed and who is available to testify again without undue burden. The successor judge may also recall any other witness."

Federal Regulations

CODE OF FEDERAL REGULATIONS
TITLE 32 - NATIONAL DEFENSE
SUBTITLE A - DEPARTMENT OF DEFENSE
CHAPTER VI - DEPARTMENT OF THE NAVY
SUBCHAPTER C - PERSONNEL
PART 721 - STANDARDS OF CONDUCT
Current through July 22, 1997; 62 FR 39398

(j) Outside employment of naval personnel.

(1) [Naval personnel shall not engage in outside employment or any other outside activity with or without compensation that:]

(i) [Interferes with or is not compatible with the performance of their Government duties;]

(ii) [May reasonably be expected to bring discredit upon the Government or the Department of the Navy; or]

(iii) [Is otherwise inconsistent with the requirements of this instruction] including the requirement to avoid actions and situations which reasonably can be expected to create the appearance of a conflict of interest.

(2) Enlisted naval personnel on active duty may not be ordered or authorized to leave their post to engage in a civilian pursuit, business, or professional activity if it interferes with the customary or regular employment of local civilians in their art, trade, or professions. See 10 U.S.C. 974.

(3) Active duty Regular officers of the Navy and Marine Corps, including those on terminal leave, shall not be employed by any person or entity furnishing naval supplies or war materials to the United States. If such an officer is so employed, he or she is not entitled to payment from the United States for the

duration of that employment, pursuant to 37 U.S.C. 801(a).

(4) Off-duty employment of military personnel by an entity involved in a strike is permissible if the person was on the payroll of the entity prior to the commencement of the strike and if the employment is otherwise in conformance with the provisions of this instruction. After a strike begins and while it continues, no military personnel September 8, 2000 may accept employment by that involved entity at the strike location.

(1) Use of Government facilities, property, and manpower. [Naval personnel shall not directly or indirectly use, take, dispose of, or allow the use, taking, or disposing of Government manpower, property or facilities of any kind, including property leased to the Government, f or other than official government business or purpose.] Naval personnel have a positive duty to protect and conserve Government property. Waste or abuse of any Government asset will not be tolerated. See SECNAVINST 5430.92. These provisions do not preclude the use of Government facilities for approved activities in furtherance of naval community relations, provided they do not interfere with military missions or Government business. See SECNAVINST 5720.44 (series) for community relations guidance.

[50 FR 15891, April 23, 1985]

Authority: 5 U.S.C. 301; 10 U.S.C. 133 and 5031; E.Q. No. 11222, May 8, 1965; 5 CFR Part 735; 32 CFR Part 40

Source: 43 FR 43070, Aug. 26, 1997; 50 FR 9000, March 6, 1985, unless otherwise noted.

California Statutes

California Business & Professions Code *2337: " . . . Notwithstanding any other provision of law, review of the superior court's decision shall be pursuant to a petition for an extraordinary writ."

Code of Civil Procedure *1094.5(c): "(c) Where it is claimed that the findings are not supported by the evidence, in cases in which the court is authorized by law to exercise its independent judgment on the evidence, abuse of discretion is established if the court determines that the findings are not supported by the weight of the evidence. In all other cases, abuse of discretion is established if the court determines that the findings are not supported by the weight of the evidence. In all other cases, abuse of discretion is established if the court determines that the findings are not supported by substantial evidence in the light of the whole record."

First Appellate District, Division Two
No. A075251/A075493
S068095

IN THE SUPREME COURT OF CALIFORNIA
EN BANC

ALLYN BETH LANDAU, Petitioner

v.

SAN FRANCISCO COUNTY SUPERIOR COURT,

Respondent

MEDICAL BOARD OF CALIFORNIA,

Real Party in Interest

(Filed June 14, 2000)

Appellant's "Notice of Motion and Motion to Issue Briefing and to Add Issue on Review," filed May 17, 2000, is denied.

Pursuant to rule 29.4(c), California Rules of Court, the above-entitled review is DISMISSED and cause is remanded to the Court of Appeal, First Appellate District, Division Two.

The Reporter of Decisions is directed to partially publish the opinion in the above-entitled case in accord with the Court of Appeal's prior partial publication of the opinion at 60 Cal.App.4th 940.)

George
Chief Justice

Baxter
Associate Justice

Werdegar
Associate Justice

Chin
Associate Justice

Associate Justice

Associate Justice

Associate Justice

Court of Appeal, First District, Division 2, California.
Allyn Beth LANDAU, M.D., Petitioner,

v.

The SUPERIOR COURT of The City and County of San Francisco, Respondent;
MEDICAL BOARD OF CALIFORNIA,
Real Party in Interest.
Allyn Beth LANDAU, M.D.,

v.

MEDICAL BOARD OF CALIFORNIA,
Defendant and Respondent.
Nos. A075251, A075493.
Jan. 12, 1998.
Certified for Partial Publication*

As Modified Jan. 16, 1998.
Rehearing Denied Feb. 4, 1998.
Review Granted April 15, 1998.

Tony J. Tanke, Tanke & Willemsen, Redwood City, for Plaintiff and Appellant Dr. Landau.

Daniel E. Lungren, Attorney General, Robert L. Mukai, Chief Assistant Attorney General, Alvin J. Korobkin, Senior Assistant Attorney General, Vivien Hara Hersh, Supervising Deputy Attorney General, Alfredo Terrazas, Deputy Attorney General, for Defendant and Respondent Medical Board of California.

---

*Pursuant to California Rules of Court, rules 976(b) and 976.1, the opinion is certified for publication with the exception of Parts III, IV and VI.

INTRODUCTION

KLINE, Presiding Justice.

In this opinion, we consider, among other things, the constitutionality of the provision of Business and Professions Code section 2337 requiring that appellate court review of a superior court decision reviewing the revocation, suspension or restriction of a physician's medical license by the Medical Board of California be by way of a petition for extraordinary writ. We shall conclude the statute is constitutional.

Effective March 16, 1996, the Medical Board of California revoked the medical license of Dr. Allyn Beth Landau, following extensive administrative proceedings before an administrative law judge. The San Francisco Superior Court denied her petition for a writ of administrative mandamus (Code Civ. Proc., § 1094.5). Dr. Landau filed both an appeal (A075493) and, pursuant to Business and Professions Code section 2337, a petition for a writ of mandate (A075251) challenging the superior court decision.

We consolidated the appeal and the writ petition and ordered supplemental briefing on the legislative history of Business and Professions Code section 2337. We issued an order to show cause in connection with the writ petition.

Dr. Landau challenges the actions of the administrative law judge (ALJ), the Medical Board of California, and

the superior court on numerous grounds.[1] In this opinion, we reject her claims that Business and Professions Code

---

[1] Claims of error raised by Dr. Landau both in her appeal and on her writ petition include the following:

1. She was denied procedural due process during the administrative proceedings by the ALJ's refusal to admit, on the grounds of hearsay, prior reports of experts retained by the Medical Board who had determined there existed no grounds for prosecuting her for negligence or incompetence.

2. She was denied due process by the ALJ's allowing the prosecutor to use stolen privileged documents during the hearing. (The ALJ in fact ruled these documents inadmissible.)

3. The failure of the Medical Board to identify which of its members revoked her license violated the Medical Practice Act and denied her due process.

4. The trial court failed to apply the independent review standard to its review of the administrative proceedings and refused to consider the "clear and convincing" standard applicable in the administrative proceeding.

5. The findings of gross negligence upheld by the superior court are not supported by the medical evidence.

6. The ALJ and the superior court erred in rejecting Dr. Landau's affirmative defense of discriminatory enforcement and discipline.

7. The Medical Board prosecution was barred by laches.

8. The maximum penalty of revocation was arbitrary and excessive.

9. Application of Business and Professions Code section 2337 to this case violates the presumption against retroactive application of a statute, violates her constitutional rights to due process and equal

section 2337 unconstitutionally denies her right to a direct appeal, accompanied by an entitlement to oral argument and a written opinion on the merits; denies her both equal protection and due process of the law; and in her case constitutes an impermissible retroactive application of the statute. We shall therefore dismiss the appeal. On the merits of her writ petition, we shall affirm the judgment and deny the petition.

STATEMENT OF FACTS/STATEMENT OF THE CASE

On April 29, 1993, the Medical Board of California (hereafter "Board" or "Medical Board") filed two separate causes for disciplinary action, seeking revocation of Dr. Landau's medical license for alleged multiple and serious violations of the Medical Practice Act in the care and treatment of two patients in 1986 and 1987. (Bus. & Prof.Code, § 2000, et.seq.)

The allegations centered around the care and treatment of two patients, S.B., a 37-year-old male and J.Y., a 27-year-old female. On December 20, 1995, following a nine-day administrative hearing, Administrative Law Judge Michael C. Cohn issued a detailed "Proposed Decision" finding cause for disciplinary action against Dr. Landau. The ALJ found such cause was established for gross negligence (Bus. & Prof.Code, § 2234, subd. (b)), as Dr. Landau's failure to follow-up with patients S.B. and J.Y. to advise them of suspicious and/or inconclusive

---

protection of the laws, and denies her right to an appeal under article VI, section 11, of the California Constitution.

biopsy results constituted in each instance an extreme departure from the standard of care. (Proposed Decision, Findings Nos. 20 and 34, Determination of Issues Nos. 2 and 5.) Cause for disciplinary action was further established for gross negligence (Bus. & Prof.Code, § 2234, subd. (b)) and/or incompetence (Bus. & Prof.Code, § 2234, subd. (d)) by reason of Dr. Landau's allowing her medical assistant to evaluate and remove pigmented lesions from J.Y., including taking samples for biopsy, which conduct constituted an extreme departure from the standard of medical care. (Proposed Decision, Finding No. 30, Determination of Issues No. 3.) The ALJ determined that the public interest demanded revocation of Dr. Landau's certificate to practice medicine. (Proposed Decision, Determination of Issues No. 7.)

On February 15, 1996, the Division of Medical Quality of the Medical Board of California adopted the Proposed Decision of the ALJ, revoking Dr. Landau's certificate of licensure as a physician and surgeon, effective March 16, 1996. (Order dated Feb. 15, 1996.)

On March 15, 1996, on Dr. Landau's ex parte application, the superior court issued a two-week stay order of the Medical Board's decision revoking her license and scheduled an expedited hearing on her Code of Civil Procedure section 1094.5 petition for writ of mandate.

On April 1, 1996, after conducting oral argument, the court filed its eight-page order denying the petition for writ of mandate. The court discharged the stay and ordered the Medical Board to prepare a statement of decision in conformity with the court's order.

On April 16, 1996, Dr. Landau moved for a new trial and for an order setting aside and vacating the judgment. On June 5, 1996, the superior court denied these motions and filed a detailed 17-page statement of decision.

On August 6, 1996, appellant filed a notice of appeal. On August 12, 1996, the Medical Board filed an objection to the notice of appeal on the grounds that pursuant to Business and Professions Code section 2337 this court lacked jurisdiction to take action on anything other than a petition for extraordinary writ. On August 12, 1996, Dr. Landau filed a petition for extraordinary writ. On December 23, 1996, we issued an order that the writ petition and the appeal would be considered together and on July 31, 1997 we issued an order to show cause on the petition for extraordinary writ.

I.

WRIT REVIEW vs. APPEAL

Review of a decision of the Division of Medical Quality revoking, suspending or restricting a medical license is by writ of administrative mandamus in the superior court. (Code Civ. Proc., § 1094.5.) Traditionally, review of the superior court decision has been by direct appeal[2] from the final judgment or order of the superior court granting or denying the writ petition. Effective January 1, 1996, the Legislature has provided that appellate review

---

[2] Subsequent references in this opinion to "direct appeals" should be understood to mean a procedure for appellate review that includes oral argument, a decision on the merits, and a written opinion. (*See Powers v. City of Richmond* (1995) 10 Cal.4th 85, 91, fn. 1, 40 Cal.Rptr.2d 839, 893 P.2d 1160.)

of the superior court's decision shall be pursuant to a petition for an extraordinary writ. (Bus. & Prof.Code, § 2337.)[3]

This amendment eliminated direct appeal via Code of Civil Procedure section 1094.5 from the superior court decision granting or denying the petition for writ of mandate and substituted discretionary writ review by the appellate court. Dr. Landau contends this provision cannot be applied to deny her a direct appeal from the superior court judgment. In the alternative, she argues she is entitled to issuance of an alternative writ or an order to show cause "because she will have no adequate remedy at law." The Medical Board contends Dr. Landau is entitled to neither issuance of an alternative writ or order to show cause nor to direct appeal of the superior court decision.

We recognize that issuance of the order to show cause in this case has arguably rendered this issue moot, as Dr. Landau has been afforded oral argument, a decision on the merits and a written opinion. Nevertheless, we examine her claim, which amounts to an assertion that

---

[3] "Notwithstanding any other provision of law, superior court review of a decision revoking, suspending, or restricting a license shall take preference over all other civil actions in the matter of setting the case for hearing or trial. The hearing or trial shall be set no later than 180 days from the filing of the action. Further continuance shall be granted only on a showing of good cause".

"Notwithstanding any other provision of law, review of the superior court's decision shall be pursuant to a petition for an extraordinary writ. " (Bus. & Prof.Code, § 2337, as amended by Stats.1995, ch. 708, § 10.5, italics added.)

in every case to which Business and Professions Code section 2337[4] applies, and in which a timely, procedurally sufficient petition is filed, the appellate court must issue an alternative writ or order to show cause. In this assertion, she is simply wrong. We therefore consider Dr. Landau's claims that in relegating her to review by extraordinary writ, the statute runs afoul of *Powers v. City of Richmond, supra,* 10 Cal.4th 85, 40 Cal.Rptr.2d 839, 893 P.2d 1160, denies her equal protection of the laws, and violates her due process rights.

A. Powers v. City of Richmond.

Both Dr. Landau and the Medical Board rely upon the recent California Supreme Court opinion *Powers v. City of Richmond, supra,* 10 Cal.4th 85, 40 Cal.Rptr.2d 839, 893 P.2d 1160 [hereafter *Powers*], upholding the constitutionality of section 6259, subdivision (c) of the Public Records Act (Gov.Code, § 6250 et seq.; hereafter PRA), providing that superior court decisions in PRA cases are not appealable but instead are "immediately reviewable by petition to the appellate court for the issuance of an extraordinary writ." Dr. Landau claims the lead opinion supports her assertion that a writ petition pursuant to section 2337 may not be summarily denied because there is no adequate remedy by way of appeal.

In *Powers,* the lead opinion of Justice Kennard, joined by Justices Baxter and Werdegar, stated that article VI,

---

[4] All statutory references to section 2337 are to the Business and Professions Code unless otherwise indicated.

section 11 of the California Constitution[5] does not confer upon litigants a right of direct appeal from final orders and judgments in proceedings in which superior courts exercise original jurisdiction. (*Id.* at pp. 91-93, 40 Cal.Rptr.2d 839, 893 P.2d 1160.) Rather, the term "appellate jurisdiction" used therein is simply the power of a reviewing court to correct error in a trial court proceeding. "By common understanding, a reviewing court may exercise this power in the procedural context of a direct appeal, a writ petition, or otherwise." (*Id.* at p. 93, 40 Cal.Rptr.2d 839, 893 P.2d 1160.) The grant of judicial authority contained in the constitutional provision has been interpreted to mean that "although the Legislature may regulate the mode of appellate review, it may do so only to the extent that it does not thereby ' "substantially impair the constitutional powers of the courts, or practically defeat their exercise." ' [Citations.] If it could be demonstrated in a given case, or class of cases, that, for whatever reason, the Courts of Appeal or this court could not effectively exercise the constitutionally granted

---

[5] "The Supreme Court has appellate jurisdiction when judgment of death has been pronounced. With that exception courts of appeal have appellate jurisdiction when superior courts have original jurisdiction and in other causes prescribed by statute.

"Superior courts have appellate jurisdiction in causes prescribed by statute that arise in municipal courts in their counties.

"The Legislature may permit appellate courts to take evidence and make findings of fact when jury trial is waived or not a matter of right." (Cal. Const., art. VI, § 11.)

power of appellate review by an extraordinary writ proceeding, then such a proceeding could not constitutionally be made the exclusive mode of appellate review." (*Id.* at p. 110, 40 Cal.Rptr.2d 839, 893 P.2d 1160.) Dr. Landau makes no such claim here.

The *Powers* lead opinion addressed the "misperception" that "appellate review by extraordinary writ petition is inherently less effective than a remedy by direct appeal because issuance of the extraordinary writs is discretionary whereas direct appeal guarantees a decision on the merits." (*Id.* at p. 113, 40 Cal.Rptr.2d 839, 893 P.2d 1160.) Observing that the discretionary aspect of writ review comes into play primarily when the petitioner has another remedy by appeal and the issue is whether the alternative remedy is adequate, the lead opinion then observed: "When an extraordinary writ proceeding is the only avenue of appellate review, a reviewing court's discretion is quite restricted. . . . [W]hen writ review is the exclusive means of appellate review of a final order or judgment, an appellate court may not deny an apparently meritorious writ petition, timely presented in a formally and procedurally sufficient manner, merely because, for example, the petition presents no important issue of law or because the court considers the case less worthy of its attention than other matters." (*Id.* at pp. 113-114, 40 Cal.Rptr.2d 839, 893 P.2d 1160, italics added.) Thus, the lead opinion recognizes that summary disposition of a writ petition is appropriate where a petition is formally and procedurally sufficient, but appears to the appellate court to be without merit. This reading of the lead opinion is verified by its rejection of the dissent's assertion that the PRA reveals "a legislative intent to invest the

Courts of Appeal with discretion to summarily deny extraordinary writ petitions on grounds unrelated to the merits of the PRA action or to the formal or procedural sufficiency of the petition." (*Id.* at p. 114, fn. 19, 40 Cal.Rptr.2d 839, 893 P.2d 1160.) Observing that the Legislature had disclosed no purpose to alter established rules of law governing extraordinary writs, the lead opinion reaffirmed that "an appellate court may deny an extraordinary writ petition summarily – that is, without issuing an alternative writ or order to show cause, without affording the parties an opportunity for oral argument, and without issuing a written opinion – and that this power of summary denial distinguishes writ review from direct appeal." (*Id.* at p. 114, fn. 19, 40 Cal.Rptr.2d 839, 893 P.2d 1160.)

Accordingly, the lead opinion recognizes that an appellate court retains discretion to summarily deny extraordinary writ petitions on grounds related to the apparent merits of the action as well as upon grounds related to the formal or procedural sufficiency of the petition.

In a concurring opinion, Justice George, joined by Justice Arabian, agreed with the lead opinion's conclusion that Government Code section 6259, subdivision (c) could constitutionally limit appellate review of trial court rulings on claims brought under the PRA to petitions for extraordinary writ. (*Id.* at pp. 115-116, 40 Cal.Rptr.2d 839, 893 P.2d 1160.) However, the concurring justices would limit the holding to the specific PRA provision at issue. They refused to join the lead opinion in announcing a "broad constitutional rule that may be understood to

validate virtually all, or at least most, legislative measures that in the future might substitute writ review for direct appeal in contexts not presented by the case now before us." (*Id.* at p. 116, 40 Cal.Rptr.2d 839, 893 P.2d 1160.) The concurring justices observed that "in enacting the statutory provision here at issue, the Legislature simply has concluded that, because of the special importance of obtaining a very prompt appellate resolution in the relatively small and discrete class of cases brought under the Public Records Act, appellate review of a superior court ruling in such cases should proceed by extraordinary writ rather than by direct appeal." (*Id.* at p. 117, 40 Cal.Rptr.2d 839, 893 P.2d 1160, italics in original.) Further, the legislative background of the PRA demonstrated that Government Code section 6259, subdivision (c) was not enacted to diminish the rights of individuals seeking disclosure under the act, but "for the general purpose of enhancing such persons' rights by ensuring that appellate review of trial court decisions under the act is conducted in a manner that promotes, rather than frustrates, the purpose of the act." (*Id.* at p. 118, 40 Cal.Rptr.2d 839, 893 P.2d 1160.) The concurring opinion observed the plaintiffs had not contended that superior court actions under the PRA were "so factually or legally complex that the Legislature could not reasonably have concluded that the Courts of Appeal properly could review trial court orders in such cases through the traditional extraordinary writ procedure, rather than the more elaborate and time consuming process of a direct appeal." (*Id.* at p. 121, 40 Cal.Rptr.2d 839, 893 P.2d 1160.) Nor did the plaintiffs contend there was anything in the nature of the particular rights or interests at stake in a PRA proceeding such that

limiting appellate review of a trial court ruling to review by extraordinary writ inadequately would protect the interests at issue. (Ibid.)

In dissent, Justices Lucas and Mosk argued that California Constitution article VI, section 11 confers upon litigants a right of direct appeal of a judgment of the superior court finally resolving a cause of action within the original jurisdiction of the superior court. According to the dissent, although the Legislature may condition direct appeal upon prior "exhaustion" of writ review procedures, it may not substantially impair the constitutional right of appeal by barring appeal in cases in which the litigants first properly sought, but were summarily denied, writ review. (*Id.* at pp. 124, 128, 183, 40 Cal.Rptr.2d 839, 893 P.2d 1160.)

Our review of Business and Professions Code section 2337 in light of *Powers*, the legislative history[6] and the statutory purpose persuades us that the statute does not run afoul of article VI, section 11 of the California Constitution.

Section 2337 was originally enacted as part of Senate Bill (SB) 2375 introduced by Senator Robert Presley in

---

[6] At our request, the parties have provided extensive analysis of the legislative history of this measure. We take judicial notice of this legislative history and supporting documentation. (Evid.Code, §§ 451, 452, 459; *Schmidt v. Southern Cal. Rapid Transit Dist.* (1993) 14 Cal.App.4th 23, 30, fn. 10, 17 Cal.Rptr.2d 340, "In a search to discern legislative intent, an appellate court is entitled to take judicial notice of the various legislative materials, including committee reports, underlying the enactment of a statute.")

1990 (Statutes of 1990, Chapter 1597), as a component of a comprehensive overhaul of the physician discipline system operated by the Medical Board of California. (*See* excerpts regarding Bus. & Prof.Code, § 2337 from all versions of SB 2375.) The bill was sponsored by The University of San Diego's Center for Public Interest Law as a reaction to a crisis in the system for physician discipline. (Analysis of SB 2375, as amended June 4, 1990, prepared for the Senate Committee on the Judiciary.) As described in the Enrolled Bill Report of the State and Consumer Services Agency, Department of General Services: "This bill is sponsored by the Center for Public Interest Law. . . . It stems from a study on the MBC [Medical Board of California], the results of which were published in an April, 1989 report entitled 'Physician Discipline in California: A Code Blue Emergency.' That study concluded that vast changes were needed in the discipline system for medical professionals, including a means of increasing the number of professionals being disciplined and methods for short-cutting the lengthy hearing and appeal process. The Consumers Union and other consumers and patients' rights groups are in support of the bill." (State and Consumer Services Agency, General Services, Enrolled Bill Report for SB 2375 (9/4/90) at p. 1, italics added.)

Among the several concerns at which the legislation was aimed was the excessive amount of time consumed by the disciplinary process. The Senate Committee on Business and Professions Staff Report included the following comment:

"The sponsor asserts that the entire process [including administrative hearing, Superior Court review, appeal

to the Court of Appeal, petition for review to the California Supreme Court, and petition for certiorari to the U.S. Supreme court] takes up to 8 years to complete, during which time the physician continues to practice. The Medical Board, however, indicates that in nearly all cases, this process takes about 3 years and that only one or two unique cases in the past have taken up to 8 years to complete." (Analysis of SB 2375 prepared for the Senate Committee on Business and Professions, at p. 2.)

As the Center for Public Interest Law Report indicated, appellate review played a major part in the overall duration of the disciplinary process. "Court of Appeal review normally takes several years to complete." (Center for Public Interest Law, Physician Discipline in California: A Code Blue Emergency (April 5, 1989) p. 22.) The Center for Public Interest Law advocated elimination of superior court review entirely, to be replaced by "direct appeal" to the Court of Appeal. (Analysis of SB 2375 prepared for the Senate Committee on Business and Professions p. 7.) Although at one point incorporated in the bill, the elimination of superior court review was eventually taken out of the measure. (*See*, Letter from Robert Fellmeth and Steve Barrow of Center for Public Interest Law to Senator Presley (May 1990) regarding SB 2375.)

In 1993, Senator Presley introduced SB 916, described in the Senate Business and Professions Committee Report as intended "to reform and improve the system for disciplinary enforcement over licensees of the Medical Board." Senator Presley described SB 916 as a "follow up" to SB 2375. (Senate Business and Professions Committee Report on SB 916, for hearing date April 12, 1993, p. 5.) As

originally introduced, SB 916 amended Business and Professions Code section 2337 to eliminate superior court review of decisions of the Medical Board, providing instead that "review of final decisions of an administrative law judge from the Medical Quality Hearing Panel shall be exclusively by appeal directly to the Third District Court of Appeal, which shall exercise its independent judgment in its review of the proceedings below." (SB 916, introduced by Senator Presley, March 3, 1993 § 25, at p. 32.) As it progressed through the Legislature in 1993, the language of section 2337 was changed to restore superior court review until January 1, 1995, but also to provide for elimination of superior court review to be replaced by review in the appellate courts by writ of mandamus pursuant to Code of Civil Procedure section 1094.5 beginning January 1, 1995, and operative until January 1, 1999. (SB 916, c. 1267, filed with Secretary of State October 11, 1993.) Before this provision for direct review in the Court of Appeal became effective, it was amended to extend the effective date to January 1, 1996. (Statutes of 1994, ch. 1206, § 23, p. 16.)

In February 1995, Senator Herschel Rosenthal introduced SB 609 at the request of the Medical Board "in order to close loopholes in existing law relating to the reporting of felony convictions of physician[s] and surgeons to the MBC [Medical Board of California] and in order to increase the enforcement capabilities of the MBC." (Senate Business and Professions Committee Report on SB 609, for hearing date April 3, 1995, p. 2.)

On July 7, 1995, SB 609 was amended in the Assembly to add new sections 10.5 and 10.7 to the bill. These amendments repealed that part of section 2337 providing

for direct review of Medical Board decisions in the Court of Appeal effective January 1, 1996. Instead, superior court review would remain in effect and appeal of the superior court's decision would be "by means of a writ of review pursuant to section 1067 of the Code of Civil Procedure." (SB 609, as amended in the Assembly, July 7, 1995.) The decision to "keep in place the current process of board disciplinary decisions by the superior court and to eliminate the direct appellate review process established two years ago with enactment of SB 916 (Presley)" came in response to concerns raised by the California Judicial Council. (Assembly Committee on Health Report on SB 609, July 11, 1995.)

On August 10, 1995, the California Medical Association (CMA) wrote to the Executive Director of the Medical Board of California suggesting further amendments including changing the language of section 2337 to provide that "Notwithstanding any other provision of law, review of the Superior Court's decision shall be by way of extraordinary writ." (Letter from Timothy J. Shannon, Jr., of CMA to Dixon Arnett of MBC, August 10, 1995, contained in legislative bill file of the Senate Committee on Business and Professions on SB 609, pp. 40-42.)

On August 21, 1995, SB 609 was amended in the Assembly so that the second paragraph of section 2337 reads as it does now. (SB 609 as amended in Assembly August 21, 1995, pp. 21-22.)

On September 8, 1995, the Attorney General wrote to Senator Rosenthal arguing for deletion of this provision on the basis that it could prejudice the Medical Board,

and thereby the public, which – in the event of an erroneous superior court decision – would be "totally dependent upon the court of appeal granting a petition for an extraordinary writ, something which it rarely does today." (Letter from Attorney General to Hon. Herschel Rosenthal (Sept. 8, 1995) re: SB 609, Request for Deletion of Section 10.5, from the legislative bill file of Senator Rosenthal on SB 609.)[7]

---

[7] In urging Senator Rosenthal to delete section 10.5 (the appellate court writ review provision) of SB 609, the Attorney General argued in pertinent part:

> "The meaning of section 10.5 of SB 609 is that the existing right of appeal which is available when a superior court improperly grants a writ of mandate against the Medical Board of California or the Board of Podiatric Medicine under Code of Civil Procedure section 1094.5, will be extinguished. The boards would instead be totally dependent upon the court of appeal granting a petition for an extraordinary writ, something which it rarely does today. This means that the public will be at risk if the superior court improperly sets aside a decision suspending or revoking the medical license of a dangerous physician and the court of appeal declines to exercise its discretion to issue an extraordinary writ. "Section 10.5, when considered in conjunction with another newly-amended provision of SB 609, also has a strong tendency to withdraw disciplinary authority from the affected multi-member bodies and instead concentrate it in decisions of individuals within state government and the judiciary. Current law empowers the boards themselves to decide cases on consideration of the evidentiary record of the hearings. Section 10.1 of SB 609 instead requires the affected boards to 'give great weight to the findings of fact' made by the individual employed to hold the

The Legislature passed SB 609 unanimously on September 11, 1995, and it was signed by the Governor on October 9, 1995. (Senate Weekly History, Thursday, February 1, 1996, part 1 of 3.) In a September 21, 1995, letter to the Governor urging signature, Senator Rosenthal reiterated that the bill "institutes the recommendations of the Judicial Council in regard to the appellate process for physician discipline cases." (Material from the Legislative file of Senator Rosenthal on SB 609.)

The legislative history of section 2337 makes clear that it was a response to one aspect of a perceived crisis in physician discipline procedures – that of lengthy delays in the final imposition of discipline. The provision for writ review in the Court of Appeal was intended to expedite the completion of judicial review of physician

---

hearing, thus concentrating in a single functionary much of the power that was intended to be exercised through the collective authority of the board's members. The decision resulting from this administrative process is then subject to review by a single superior court judge, invoked by the filing of a petition for writ of mandate by the disciplined licensee. When a writ of mandate is improperly granted, section 10.5 means that the decision of that single judge will no longer be subject to correction by obligatory appeal to the justices of the court of appeal. Thus, licensure of the affected health care professions is substantially deprived of the benefit of the board's expertise over licensing decisions, and of the collective wisdom of the court of appeal bearing upon the process of judicial review." (Letter from Attorney General to Hon. Herschel Rosenthal (Sept. 8, 1995) re: SB 609, *supra*, fn. omitted, emphasis in original.)

discipline decisions and to shorten the overall time for these cases irrespective of which party prevailed at the superior court level.

Dr. Landau does not dispute that writ review will accomplish the goal of shortening the overall time for these cases by expediting judicial review. In cases where the Board has imposed discipline, suspending or revoking a license, and the superior court has refused to issue a writ overturning that decision, appellate review by writ of mandate enables the appellate court to dispose of a petition that has no apparent merit relatively quickly. Similarly, where the superior court has issued a writ overturning the Board's imposition of discipline, appellate writ review pursuant to section 2337 would benefit the physician by shortening the time to final decision.[8]

As we read the *Powers* lead and concurring opinions, a majority of our Supreme Court does not require an alternative writ or order to show cause issue in every instance in which a timely, procedurally sufficient, but apparently meritless writ petition is filed. Indeed, such

---

[8] We note that the benefits of speed which are envisioned by the statute are most likely to occur in cases where the claim raised by the writ petition is without apparent merit and suitable for summary disposition. Once an order to show cause has issued, the matter becomes a cause and is put on calendar for oral argument and disposition. In such cases, the time consumed by the writ proceeding will often be no different from that which would be required if the matter proceeded by direct appeal.

requirement would undermine the purpose of speedy resolution.[9]

Dr. Landau asserts that, unlike the PRA at issue in *Powers*, physician discipline cases subject to section 2337 are likely to be both factually and legally complex. She makes no attempt to explain why physician discipline cases are likely to be more complex than cases arising under the PRA or any other class of cases, and we do not view this case as so complex either factually or legally as to render it inappropriate for writ review.

Dr. Landau further argues the public interest will be adversely affected by denial of direct appeal in cases where the Medical Board is seeking review of a superior court decision overturning the Board's discipline of a physician. This mirrors a concern raised by the Attorney

---

[9] We are mindful that summary denial of a writ petition is not "on the merits" for law of the case purposes. (*Kowis v. Howard* (1992) 3 Cal.4th 888, 897, 12 Cal.Rptr.2d 728, 838 P.2d 250.) Generally, this will have limited effect as law of the case doctrine is usually applied to subsequent retrial following reversal by the Court of Appeal. As a practical matter, reversal and summary denial of a writ petition are inconsistent. Reversal will usually be preceded by issuance of an alternative writ or order to show cause, making the matter a "cause" and resulting in a decision on the merits and a written opinion. The Medical Board argues that Kowis applies only to pretrial writ proceedings and not to extraordinary writ review of final judgments of the superior court. We find no authority supporting this distinction, which we think unreasonable. Indeed, as a writ petition may be summarily denied because it is not timely or procedurally sufficient, it is clear that not all summary denials of such writ petitions will be on the merits. If summary denial of a writ petition prevents application of law of the case principles, so be it.

General in his September 8, 1995 letter to Senator Rosenthal. The Legislature reasonably could determine that the public interest was better protected by expediting resolution of physician discipline cases than by requiring oral argument and a written opinion in every instance of appellate review of the superior court's judgment reviewing the discipline decision of the Medical Board.[10]

B. Equal Protection Claim.

Dr. Landau asserts that in depriving her of the option of a direct appeal section 2337 violates her equal protection rights by treating physicians differently from other licensed professionals. She contends her right to continue to practice her licensed profession is fundamental and that we must therefore review her equal protection claim under the strict scrutiny standard of review. We disagree.

"[T]he equal protection clause requires that those similarly situated not be treated differently unless the disparity is justified." (*Board of Supervisors v. Local Agency Formation Com.* (1992) 3 Cal.4th 903, 914, 13 Cal.Rptr.2d 245, 838 P.2d 1198; *Kenneally v. Medical Board* (1994) 27

---

[10] Nor do we subscribe to Dr. Landau's argument that the Legislature did not know it was making review discretionary when it amended section 2337 to make review pursuant to a petition for extraordinary writ, rather than by direct appeal. The language of the section speaks for itself.

Clearly, reference to prior versions of the statute when appeal was to the Court of Appeal directly does not indicate the Legislature did not understand what it was doing in eliminating these provisions and replacing them with the current language.

Cal.App.4th 489, 495, 32 Cal.Rptr.2d 504.) "The Fourteenth Amendment's guarantee of equal protection and the California Constitution's protection of the same right (Cal. Const., art. I, § 7, subd. (a), art. IV, § 16, subd. (a)) are substantially equivalent and are analyzed in a similar fashion. [Citations.]" (*Kenneally v. Medical Board, supra,* at p. 495, 32 Cal.Rptr.2d 504.)

"In considering an equal protection challenge, 'we must first determine the appropriate standard of review. [Citation.] The proper standard of review, as developed by the high court, depends upon the classification involved in, and interests affected by, the challenged law.' (*Bowens v. Superior Court* (1991) 1 Cal.4th 36, 42) [2 Cal.Rptr.2d 376, 820 P.2d 600] The traditional approach involves two tiers. [Fn. omitted.] 'The challenged law will be subject to strict scrutiny only if it operates to the peculiar disadvantage of suspect class [citation] or impinges on a fundamental right [citation].' (Ibid.; *Board of Supervisors v. Local Agency Formation Com., supra,* 3 Cal.4th at p. 913 [13 Cal.Rptr.2d 245, 838 P.2d 1198].) 'Under this very severe standard, a discriminatory law will not be given effect unless its classification bears a close relation to the promoting of a compelling state interest, the classification is necessary to achieve the government's goal, and the classification is narrowly drawn to achieve the goal by the least restrictive means possible." (*Board of Supervisors v. Local Agency Formation Com., supra,* 3 Cal.4th at p. 913 [13 Cal.Rptr.2d 245, 838 P.2d 1198].)

"Recognizing it is the Legislature's responsibility to draw distinctions between groups, and the lines can rarely be precisely drawn, courts generally apply the

rational basis test to most legislation. The rational basis test is routinely applied in areas of economic regulation. (*Rittenband v. Cory* (1984) 159 Cal.App.3d 410, 417 [205 Cal.Rptr. 576]) 'The "standard formulation of the test for minimum rationality" [citation] is whether the classification is "rationally related to a legitimate governmental purpose." [Citation.] Put another way, the classification must bear some fair relationship to a legitimate public purpose.' (*Board of Supervisors v. Local Agency Formation Com., supra,* 3 Cal.4th at p. 913 [13 Cal.Rptr.2d 245, 838 P.2d 1198].)" (*Kenneally v. Medical Board, supra,* 27 Cal.App.4th 489, 495-496, 32 Cal.Rptr.2d 504.)

Kenneally v. Medical Board, supra, 27 Cal.App.4th 489, 32 Cal.Rptr.2d 504 is dispositive of Dr. Landau's claim that she has a fundamental right to continue to practice her licensed profession. In *Kenneally,* a physician contended that Government Code section 11511 denied him equal protection (U.S. Const., 14th Amend.; Cal. Const., art. I, § 7) by restricting prehearing depositions in physician disciplinary proceedings. The Court of Appeal refused to utilize strict scrutiny review and held the rational basis test was the standard of review applicable to the doctor's claim.

The *Kenneally* court reasoned: " '[T]here is no fundamental constitutional right to work for, or to have continued employment with, a particular public or private employer.' [Citations.]" (*Kenneally v. Medical Board, supra,* 27 Cal.App.4th at p. 496, 32 Cal.Rptr.2d 504.)

"Nor is there a distinction for equal protection purposes between the obtaining of a professional license and the maintaining of that license. [Citation.] 'No person can

acquire a vested right to continue, when once licensed, in a business, trade or occupation which is subject to legislative control under the police powers.' [Citation.] '[T]o the extent the license is subject to the state's police power, it is not vested.' [Citations.]" (*Id.* at p. 497, 32 Cal.Rptr.2d 504.)

Further, *Kenneally* distinguished cases, such as those cited by Dr. Landau, which refer to the right to practice a lawful occupation as "vested" or "constitutionally protected." (*Laisne v. Cal. St. Bd. of Optometry* (1942) 19 Cal.2d 831, 834, 123 P.2d 457.)[11] "Language from cases that discuss a trial court's independent review of administrative proceedings on mandamus does not compel the conclusion an individual has a fundamental right for equal protection purposes to his occupation. In this situation, the courts have called one's occupation 'fundamental.'

---

[11] Other cases cited by Dr. Landau in support of the application of strict scrutiny do not apply that level of review and do not even address the issue. *Hewitt v. Board of Medical Examiners* (1906) 148 Cal. 590, 84 P. 39 held provisions of a statute authorizing the Board of Medical Examiners to revoke the certificate of a physician for "grossly improbable statements" in a advertisement of a medical business were uncertain and indefinite where the statute did not define the term "grossly improbable statements" so as to give physicians adequate notice of the grounds for revocation.

Ex Parte Hayden (1905) 147 Cal. 649, 82 P. 315 did not involve a question of fundamental rights or strict scrutiny. The question there involved a criminal prosecution for violation of a statute requiring that packages of fruit for shipment must be stamped showing the locality where the fruit was grown. The court held absent any valid police purpose for such rule, and in light of a clear purpose to give some growers advantages over others, the statute was unconstitutional.

However, our Supreme Court has made it clear that there is a distinction between an interest which is 'fundamental,' such that one receives independent judicial review after a disciplinary hearing and one which is 'fundamental,' such that strict scrutiny is applied for equal protection analysis." (*Kenneally, supra,* at pp. 497-498, 32 Cal.Rptr.2d 504, fn. omitted.)

Kenneally relied upon *Berlinghieri v. Department of Motor Vehicles* (1983) 33 Cal.3d 392, 188 Cal.Rptr. 891, 657 P.2d 383, in which the California Supreme Court found a right to a driver's license to be "fundamental" such that an administrative decision relating to the license deserved independent judicial review, but not fundamental so as to require strict scrutiny in an equal protection analysis. (*Kenneally, supra,* at p. 498, 32 Cal.Rptr.2d 504.) In contending that a medical license is more important than a driver's license, Dr. Landau misses the point. The Supreme Court in Berlinghieri clearly distinguished between the two senses in which an interest may be termed "fundamental" and " 'cautioned against any "blurring of two separate and distinct senses in which the term 'fundamental' is used. . . . " ' (*Graham v. Kirkwood Meadows Pub. Util. Dist., supra,* 21 Cal.App.4th at p. 1643 [26 Cal.Rptr.2d 793].)" (*Kenneally, supra,* at p. 498, 32 Cal.Rptr.2d 504.)

" '[T]he standard of review question with which [the administrative review] cases deal relates to the appropriate relationship between administrative and judicial adjudicatory decisions, and does not concern the constitutional legitimacy or validity of legislative policy judgments at all. Thus, . . . the "fundamental right" category does not identify areas in which substantive

legislative judgments are in any manner constitutionally suspect or justify unusual judicial scrutiny; rather, that category simply encompasses those quasi-judicial administrative decisions that have "an impact on the individual 'sufficiently vital . . . to compel a full and independent review' by the court." [Citation.] [¶] Indeed, even a cursory review of the [administrative review] line of decisions makes it abundantly clear that the applicability of the independent judgment standard of review does not in any sense suggest that legislative measures pertaining to the individual interest at issue are properly subject to strict scrutiny review.' " (*Berlinghieri v. Department of Motor Vehicles, supra,* 33 Cal.3d 392, 396-397, 188 Cal.Rptr. 891, 657 P.2d 383, italics in original; accord, *Kenneally v. Medical Board, supra,* 27 Cal.App.4th at p. 498, 32 Cal.Rptr.2d 504.)

Kenneally was followed by *California Gillnetters Assn. v. Department of Fish & Game* (1995) 39 Cal.App.4th 1145, 46 Cal.Rptr.2d 338 and *Frankel v. Board of Dental Examiners* (1996) 46 Cal.App.4th 534, 54 Cal.Rptr.2d 128.

In *California Gillnetters Assn.*, the Court of Appeal recognized the distinction between terming a right "fundamental" so as to warrant heightened judicial scrutiny of administrative rulings affecting that right and the question whether a right is fundamental for purposes of strictly scrutinizing legislative enactments regulating the right. "Recognizing that distinction, the courts have concluded that legislative enactments affecting the right to work are tested under a 'rational basis' test because there is no fundamental right to work at a particular occupation or for a particular employer." (*California Gillnetters Assn. v. Department of Fish & Game, supra,* 39 Cal.App.4th

1145, 1155, 46 Cal.Rptr.2d 338.) As the court observed in *Frankel v. Board of Dental Examiners, supra,* 46 Cal.App.4th 534, 551, 54 Cal.Rptr.2d 128, "there is no fundamental right to a professional license akin to the liberty interest which is given rigorous statutory and constitutional protection in criminal law."

We conclude Dr. Landau's right to continue to practice her licensed profession is not a fundamental right for equal protection purposes. Accordingly, in evaluating whether section 2337 denies her equal protection, we apply the rational basis test.

"States are granted the power to regulate professions. [Citation.] The state may regulate different professions differently. It may resolve identical problems with respect to different professions at the same time and in the same manner, or determine to regulate different professions differently. [Citation.] In evaluating professional disciplinary systems an appellate court does not sit as a superlegislature. [Citation.] Great deference to legislative judgment should be accorded. [Citation.]." (*Kenneally v. Medical Board, supra,* 27 Cal.App.4th 489, 499, 32 Cal.Rptr.2d 504.)

As discussed heretofore, the purpose of this legislation was to expedite the physician discipline process, which was perceived to be in crisis, and particularly to speed final resolution of such cases. Writ review at the appellate court level will have the effect of speeding review in many such cases. As *Kenneally, supra,* recognizes, "These dual purposes of streamlining and reducing the cost of disciplinary proceedings in general obtain

even greater importance in the context of physician disciplinary hearings. The medical profession is technically complex and is intertwined in an intimate relationship with the public interest and welfare. [Citation.] The work of physicians has life and death consequences for their patients. Negligent or incompetent physicians endanger the physical and mental health and lives of their patients. There is no profession in which it is more critical that errant practitioners be swiftly and expeditiously identified and disciplined." (*Id.* at pp. 500-501, 32 Cal.Rptr.2d 504, fn. omitted.)

The limitation of appellate review of superior court decisions in physician discipline cases to review by extraordinary writ, is rationally related to the governmental purposes of reducing delay in these matters. Section 2337 does not violate a physician's constitutional right to equal protection of the laws.

C. Due Process Claim.

We also reject Dr. Landau's claim that writ review denies her due process of laws. She relies upon *Honda Motor Co. Ltd. v. Oberg* (1994) 512 U.S. 415, 114 S.Ct. 2331, 129 L.Ed.2d 336, which held that due process requires some degree of judicial review of punitive damages assessed and imposed by state courts. We find that case inapposite.

In *Honda Motor Co. v. Oberg*, the Oregon Supreme Court had rejected a claim of excessive punitive damages, because the state's constitution had eliminated entitlement to review of a verdict's excessiveness. As described by the court, "[I]f the defendant's only basis for relief is

the amount of punitive damages the jury awarded, Oregon provides no procedure for reducing or setting aside that award." (*Id.* at pp. 426-427, 114 S.Ct. at 2338, italics in original.) After tracing the common law history of such review and examining the different practice uniformly found in all other states and the federal courts, the United States Supreme Court concluded: "A decision to punish a tortfeasor by means of an exaction of exemplary damages is an exercise of state power that must comply with the Due Process Clause of the Fourteenth Amendment. The common law practice, the procedures applied by every other State, the strong presumption favoring judicial review that we have applied in other areas of the law, and elementary considerations of justice, all support the conclusion that such a decision should not be committed to the unreviewable discretion of a jury." (*Id.* at pp. 434-435, 114 S.Ct. at 2342, italics added.) Opining that post-verdict judicial review – or an equivalent not there presented – was practically necessary to safeguard against arbitrary penalties, the high court held that "Oregon's denial of judicial review of the size of punitive damage awards violates the Due Process Clause of the Fourteenth Amendment." (*Id.* at p. 432, 114 S.Ct. at 2341, fn. omitted; *see Rifkind & Sterling, Inc. v. Rifkind* (1994) 28 Cal.App.4th 1282, 1289-1290, 33 Cal.Rptr.2d 828.)

The high court recognized, however, that a due process violation is not established simply by showing that traditional procedures were changed. "Of course, not all deviations from established procedures result in constitutional infirmity. As the Court noted in *Hurtado* [*Hurtado v. California* (1884) 110 U.S. 516, 4 S.Ct. 111, 28 L.Ed. 232], to hold all procedural change unconstitutional 'would be to

deny every quality of the law but its age, and to render it incapable of progress or improvement.' " (*Honda v. Oberg, supra,* at pp. 430-431, 114 S.Ct. at 2340.)

In contrast to the Oregon law at issue in *Honda Motor Co. v. Oberg, supra,* section 2337 does not eliminate judicial review or meaningful appellate review. Rather, it requires that such review be by extraordinary writ, rather than by direct appeal. The lead opinion in *Powers v. City of Richmond, supra,* 10 Cal.4th 85, 40 Cal.Rptr.2d 839, 893 P.2d 1160, explicitly rejected the contention that "appellate review by extraordinary writ petition is inherently less effective than a remedy by direct appeal" with the observation that such argument "betrays a serious misunderstanding of the discretionary character of extraordinary writs." (*Id.,* at p. 113, 40 Cal.Rptr.2d 839, 893 P.2d 1160.) The fatal due process violation in *Honda Motor Co. v. Oberg, supra,* was the abrogation by Oregon law of any meaningful judicial review of an assertedly excessive punitive damage award. We conclude the provision of section 2337 requiring that appellate review in these cases take place through extraordinary writ petition provides meaningful review and thus does not violate due process.[12]

---

[12] We note that in California, administrative agency decisions are accorded judicial review in a variety of ways. Although one of the most common review mechanisms is via petition for writ of mandate under Code of Civil Procedure section 1094.5 to the superior court, and then by direct appeal to the Court of Appeal, this is by no means universal. Judicial review of decisions of the Public Utilities Commission is via petition for a writ of review in the Court of Appeal or in the California Supreme Court. (Pub.Util.Code, §§ 1756, 1759.)

II.

RETROACTIVITY

Dr. Landau contends that relegating her to writ review constitutes impermissible retroactive application of the statute. The formal accusation against her was filed in April 1993 and the hearing before the administrative law judge occurred in 1995, with the ALJ issuing his

---

Judicial review of attorney discipline cases is by petition for review to the California Supreme Court or the California Court of Appeal. (Bus. & Prof.Code, §§ 6082, 6083.)

Judicial review of Workers' Compensation Appeals Board decisions is via petition for writ of review in the California Supreme Court or the Court of Appeal. (Lab.Code, §§ 5950-5955.)

Judicial review of Alcoholic Beverage Control Appeals Board decisions is via writ of review in the California Supreme Court or the Court of Appeal. (Bus. & Prof.Code, §§ 23090-23090.5.)

Judicial review of Agricultural Labor Relations Board decisions is by petition to the Court of Appeal. (Lab.Code, § 1160.8.)

Judicial review of Public Employment Relations Board unit determinations and unfair practice cases can be obtained only by petition for extraordinary writ to the Court of Appeal. (Gov.Code, §§ 3520, 3542, 3564.)

In a different context, we note that judicial review of the denial of a statutory preemptory challenge to a trial judge is subject to review only by extraordinary writ and may not be reviewed on direct appeal of the final judgment. (Code Civ. Proc., § 170.3; *People v. Brown* (1993) 6 Cal.4th 322, 334-335, 24 Cal.Rptr.2d 710, 862 P.2d 710.) (However, a "nonstatutory" due process claim of judicial bias may be raised on direct appeal from a final judgment. (*People v. Brown, supra*, at p. 335, 24 Cal.Rptr.2d 710, 862 P.2d 710.).)

opinion on December 20, 1995. The amendment to section 2337 became operative on January 1, 1996. (Cal. Const. art. IV, § 8, subd. (c)(1); Gov.Code, § 9600, subd. (a).) The Board adopted the ALJ's decision on February 15, 1996 and the superior court filed its decision denying Dr. Landau's petition for a writ of mandate on June 5, 1996.

Statutes are presumed to operate prospectively absent an express declaration of retrospectivity or a clear indication that the electorate, or the Legislature, intended otherwise. (*Tapia v. Superior Court* (1991) 53 Cal.3d 282, 287, 279 Cal.Rptr. 592, 807 P.2d 434 (*Tapia*); *Evangelatos v. Superior Court* (1988) 44 Cal.3d 1188, 1206-1209, 246 Cal.Rptr. 629, 753 P.2d 585 (*Evangelatos*); *Aetna Cas. & Surety Co. v. Ind. Acc. Com.* (1947) 30 Cal.2d 388, 393, 182 P.2d 159 (*Aetna Casualty.*))[13]

As both the text and legislative history of section 2337 are silent on the question of retrospectivity, we conclude the measure is to be applied prospectively only.

In *Tapia*, the Supreme Court held that certain provisions of Proposition 115 ("Crime Victims Justice Reform Act") addressing the conduct of trials and other provisions changing the law to benefit defendants could be applied to the trial of a defendant charged with a murder that occurred before the effective date of the act. Certain other provisions changing the legal consequences of criminal behavior to the detriment of defendants operated

---

[13] "Various statutes codify this rule of interpretation. (*See*, e.g., Code Civ. Proc., § 3 ['No part of [this code] is retroactive, unless expressly so declared.']; Pen.Code, § 3 [same].)" (*Tapia, supra*, p. 287, fn. 2, 279 Cal.Rptr. 592, 807 P.2d 434.)

retrospectively and could not be applied. The court determined that to the extent its provisions addressed the conduct of trials to be conducted after its enactment, the act applied prospectively. In so holding, the court elaborated upon the distinction between prospective and retrospective application of a statute.

A law addressing the conduct of trials yet to occur addresses future conduct. (*Id.* at p. 288, 279 Cal.Rptr. 592, 807 P.2d 434.) "Such a statute ' "is not made retroactive merely because it draws upon facts existing prior to its enactment. . . . [Instead,] [t]he effect of such statutes is actually prospective in nature since they relate to the procedure to be followed in the future." ' (*Strauch v. Superior Court* (1980) 107 Cal.App.3d 45, 49 [165 Cal.Rptr. 552], quoting *Olivas v. Weiner* (1954) 127 Cal.App.2d 597, 600-601) [274 P.2d 476] For this reason, we have said that 'it is a misnomer to designate [such statutes] as having retrospective effect.' [Citation.]" (*Tapia, supra,* at p. 288, 279 Cal.Rptr. 592, 807 P.2d 434.)

"[A] law governing the conduct of trials is being applied 'prospectively' when it is applied to a trial occurring after the law's effective date, regardless of when the underlying crime was committed or the underlying cause of action arose." (*Id.* at p. 289, 279 Cal.Rptr. 592, 807 P.2d 434.) Prior Supreme Court opinions, including *Aetna Casualty* and *Evangelatos* had not rejected this analysis. Rather, in those opinions, the court refused to apply a statute so as to change the legal consequences of the parties' past conduct. "In determining whether such statutes changed 'the legal effects of past events' (*Aetna Casualty, supra,* 30 Cal.2d at p. 394 [182 P.2d 159]) we sometimes used the terms 'substantive' and 'procedural.'

(*Id.* at p. 395 [182 P.2d 159]; *Evangelatos, supra,* 44 Cal.3d at p. 1226, fn. 26 [246 Cal.Rptr. 629, 753 P.2d 585].) However, we also made it clear that it is the law's effect, not its form or label, which is important. (*Aetna Casualty, supra,* 30 Cal.2d at p. 394 [182 P.2d 159]; *Evangelatos, supra,* 44 Cal.3d at pp. 1225-1226, fn. 26 [246 Cal.Rptr. 629, 753 P.2d 585].)" (*Tapia, supra,* at p. 289, 279 Cal.Rptr. 592, 807 P.2d 434.) In *Aetna Casualty, supra,* the Supreme Court annulled an award of the Industrial Accident Commission erroneously applying a statute which increased the amount of compensation for disabilities in a case involving injuries occurring prior to the statute's effective date. The court reasoned that because the law increased employers' liability for industrial disabilities, it changed the legal consequences of their past conduct. Consequently, the statute was "substantive in its effect, and its operation would be retroactive, since it imposes a new or additional liability and substantially affects existing rights and obligations." (*Aetna Casualty, supra,* at p. 395, 182 P.2d 159; accord *Tapia, supra,* at p. 290, 279 Cal.Rptr. 592, 807 P.2d 434.)

In *Evangelatos, supra,* 44 Cal.3d 1188, 246 Cal.Rptr. 629, 753 P.2d 585, the court held Proposition 51 which limited an individual tortfeasor's liability for noneconomic damages to his proportionate share of fault, could not be applied retroactively as it " 'would have a very definite substantive effect' on both plaintiffs and defendants. (*Evangelatos, supra,* 44 Cal.3d at pp. 1225-1226, fn. 6 [246 Cal.Rptr. 629, 753 P.2d 585].)" (*Tapia, supra,* at p. 290, 279 Cal.Rptr. 592, 807 P.2d 434.) As in *Aetna Casualty,* the law at issue "changed the legal consequences of the parties' past conduct. Specifically, Proposition 51 reduced the amount of damages which a plaintiff

could recover from a particular defendant and made it impossible for defendants to recover contribution for noneconomic damages." (*Tapia, supra,* at p. 290, 279 Cal.Rptr. 592, 807 P.2d 434, fn. omitted.) Although rejecting the argument that the retroactivity question could be resolved by denominating a statute as "substantive" or "procedural," "neither *Aetna Casualty, supra,* nor *Evangelatos, supra,* repudiated the general rule that statutes addressing the conduct of trials are prospective. Instead, in each case we held the rule inapplicable to statutes which changed the legal consequences of past conduct by imposing new or different liabilities based upon such conduct. [Citations.]" (*Tapia, supra,* at pp. 290-291, 279 Cal.Rptr. 592, 807 P.2d 434.)

In the instant case, Dr. Landau does not claim that the amendment to the statute changed the legal consequences of past conduct by imposing new or different liabilities based upon such conduct. Certainly, the change in review procedure had no impact upon either her treatment of the two patients or the possible liabilities or penalties arising therefrom. Nor does she contend that her decision to refuse a plea bargain was impacted by her understanding as to her appeal rights in the event the ALJ found against her, the Board adopted that decision, and the superior court denied her petition for a writ of mandate.

Nor do we view the statute as applying retroactively because the administrative hearing before the ALJ and the ALJ's ruling preceded the January 1, 1996, effective

date of the statute.[14] The amendment at issue here made no changes in the conduct of the hearing before the ALJ. *Dept. of Alcoholic Bev. Control v. Superior Court* (1968) 268 Cal.App.2d 67, 73 Cal.Rptr. 780 is analogous. There, following notice and a hearing, the Department of Alcoholic Beverage Control suspended the liquor license of real parties in interest (the Mumfords) for violations of the Alcoholic Beverage Control Act. The violations occurred in 1966. Effective November 1, 1967, the act was amended to eliminate the jurisdiction of the superior court to review final orders of the Alcoholic Beverage Control Appeals Board or to stay enforcement of a suspension order. Thereafter, review of a final Board order was by way of timely application to the Supreme Court or Court of Appeal for a writ of review. The Mumfords claimed application of the revised judicial review procedure to the decision of the department would constitute an unconstitutional retrospective application of the statute. The Court of Appeal rejected this argument as follows: "Although the alleged violations of the Act with which the Mumfords were charged occurred in 1966, administrative remedies were not exhausted until the Board filed its final order on May 8, 1968. Thus, by the time the right to judicial review matured, the amendments had been in effect for six months. The licensees had no vested right to

---

[14] "Although [Code of Civil Procedure section] 1094.5 uses the word 'trial' in referring to the proceedings at the administrative level, what ordinarily occurs is called a 'hearing.' The superior court hearing on the petition for peremptory writ of administrative mandamus is considered the trial." (California Administrative Mandamus (Cont.Ed.Bar 1989) § 4.22, p. 110.)

have the jurisdiction of the courts limited as it was when the violations occurred. (*Owens v. Superior Court*, 52 Cal.2d 822, 833 [345 P.2d 921]) The new procedures on judicial review clearly governed review of the departmental decision in question. A statute affecting procedure or providing a new remedy for the enforcement of existing rights is properly applicable to actions pending when the statute becomes effective, provided that vested rights are not thereby impaired. [Citations.] In the present case, application of the amendments involved no impairment of the licensees' right to judicial review nor a denial of an opportunity to take advantage of the benefit of the revised procedures." (*Dept. of Alcoholic Bev. Control v. Superior Court, supra*, 268 Cal.App.2d at pp. 75-76, 73 Cal.Rptr. 780.)

Dept. of Alcoholic Bev. Control v. Superior Court, supra, 268 Cal.App.2d 67, 73 Cal.Rptr. 780, was relied upon by the appellate court in *Strauch v. Superior Court* (1980) 107 Cal.App.3d 45, 165 Cal.Rptr. 552, in holding a statute which imposed on plaintiffs in malpractice suits the requirement of filing a certificate of merit operated prospectively, even as applied to causes of action accruing before the statute's effective date. (*Id.*, at p. 49, 165 Cal.Rptr. 552.) "The new statute operated prospectively because it did not 'create a new cause of action or deprive a malpractice defendant of any defense on the merits or affect vested rights.' (*Id.*, at p. 49 [165 Cal.Rptr. 552].)" (*Tapia*, at p. 289, 279 Cal.Rptr. 592, 807 P.2d 434.) *Strauch*, in turn was relied upon by the Supreme Court in *Tapia*, as was *Andrus v. Municipal Court* (1983) 143 Cal.App.3d 1041, 192 Cal.Rptr. 341 (disapproved on other grounds in *Evangelatos, supra*, 44 Cal.3d at p. 1207, fn. 11, 246

Cal.Rptr. 629, 753 P.2d 585) wherein the court immediately applied to pending appeals a new statute eliminating the right to appeal from certain orders of the superior court denying extraordinary relief. (*Tapia*, at p. 289, 279 Cal.Rptr. 592, 807 P.2d 434.)

These authorities persuade us section 2337 operates prospectively in this case.

III.-IV.**

V.

PENALTY DETERMINATION

Dr. Landau contends the Medical Board abused its discretion in revoking her medical license, characterizing revocation as the "professional death sentence." Such hyperbole is misleading. A physician whose medical certificate has been revoked may petition for reinstatement after three years. (Bus. & Prof.Code, § 2307.)[19]

** *See* footnote *, ante.

[19] Business and Professions Code section 2307 provides in relevant part:

> "A person whose certificate has been revoked or suspended or who has been placed on probation may petition the Division of Medical Quality for reinstatement or modification of penalty, including modification or termination of probation, after a period of not less than the following minimum periods have elapsed from the effective date of the decision ordering that disciplinary action:
>
> "(a) At least three years for reinstatement of a license revoked for unprofessional conduct, except that the

Dr. Landau contends the penalty was unreasonable in light of the following considerations: (1) Nothing in the record suggests Dr. Landau was grossly incompetent. (2) These were her first offenses. She had practiced for 18 years with no prior record of discipline. The offenses themselves were two almost ten-year-old instances of alleged improper follow-up and using a medical assistant to excise moles. (3) The Medical Board's failure to seek an injunction under Business and Professions Code section

---

division may, for good cause shown, specify in a revocation order that a petition for reinstatement may be filed after two years.

"....

"[c] The petition shall state any facts as may be required by the division. The petition shall be accompanied by at least two verified recommendations from physicians and surgeons licensed by the board who have personal knowledge of the activities of the petitioner since the disciplinary penalty was imposed.

"....

"The panel of the division or the administrative law judge hearing the petition may consider all activities of the petitioner since the disciplinary action was taken, the offense for which the petitioner was disciplined, the petitioner's activities during the time the certificate was in good standing, and the petitioner's rehabilitative efforts, general reputation for truth, and professional ability. . . .

"The administrative law judge designated in Section 11371 of the Government Code reinstating a certificate or modifying a penalty may recommend the imposition of any terms and conditions deemed necessary.

"...."

2312 demonstrates that it did not consider continued practice by Dr. Landau to pose a threat to public safety. (4) The Medical Board had been "out to get" Dr. Landau for years, having sought without success to prosecute her for offenses involving her office practices and having nothing to do with patient care. (5) Revocation here was arbitrary when compared with other discipline recently imposed by the Medical Board. (6) In relying in part upon her attitude and refusal to acknowledge wrongdoing, the Medical Board punished her more severely for exercising her due process rights to put on a defense. (7) There was no indication that Dr. Landau would not submit to supervision and correction.

In reviewing the severity of the discipline imposed, we look to the correctness of the agency's decision rather than that of the trial court. We review the actions of the Medical Board to determine whether the discipline imposed constituted a manifest abuse of discretion. (*Talmo v. Civil Service Commission* (1991) 231 Cal.App.3d 210, 226, 282 Cal.Rptr. 240; *Schmitt v. City of Rialto* (1985) 164 Cal.App.3d 494, 500, 210 Cal.Rptr. 788; *Cal. Administrative Mandamus, supra,* § 14.26, p. 463, *id.* (Cont.Ed.Bar.Supp. April 1996), p. 117.) "The penalty imposed by an administrative body will not be disturbed in mandamus proceedings unless an abuse of discretion is demonstrated. (*Skelly v. State Personnel Bd., supra,* 15 Cal.3d at p. 217 [124 Cal.Rptr. 14, 539 P.2d 774]; *Magit v. Board of Medical Examiners* (1961) 57 Cal.2d 74, 87 [17 Cal.Rptr. 488, 366 P.2d 816]) Neither an appellate court nor a trial court is free to substitute its discretion for that of the administrative agency concerning the degree of punishment imposed. (*Nightingale v. State Personnel Board*

(1972) 7 Cal.3d 507, 515 [102 Cal.Rptr. 758, 498 P.2d 1006])" (*Barber v. State Personnel Bd.* (1976) 18 Cal.3d 395, 404, 134 Cal.Rptr. 206, 556 P.2d 306.)

"In reviewing the exercise of this discretion we bear in mind the principle '[c]ourts should let administrative boards and officers work out their problems with as little judicial interference as possible. . . . Such boards are vested with a high discretion and its abuse must appear very clearly before the courts will interfere.' (*Maxwell v. Civil Service Commission* (1915) 169 Cal. 336 [146 P. 869]; accord *Skelly v. State Personnel Bd.* (1975) 15 Cal.3d 194, 217 [124 Cal.Rptr. 14, 539 P.2d 774])" (*Talmo v. Civil Service Commission, supra,* 231 Cal.App.3d 210, 230, 282 Cal.Rptr. 240.)

In medical discipline cases, the "highest priority" is protection of the public. (Bus. & Prof.Code, § 2229, subds. (a) and (c); *cf; Talmo v. Civil Service Commission, supra,* 231 Cal.App.3d 210, 230, 282 Cal.Rptr. 240 ["the 'overriding consideration' in cases of public employee discipline 'is the extent to which the employee's conduct resulted in, or if repeated is likely to result in, "[h]arm to the public service." ' "].)

Because we conclude that reasonable minds could differ over the appropriateness of the penalty imposed, we find no manifest abuse of discretion.

We have already determined that the findings of gross negligence were supported by substantial evidence. Dr. Landau's failures to follow up with these two patients constituted an extreme departure from the standard of care and had extremely serious consequences – S.B. in fact died.

That other cases in which revocation has been upheld involve criminal offenses, drug offenses or sexual misconduct is not determinative that revocation in the circumstances presented here was an abuse of discretion. As we have previously discussed, since 1990, the physician discipline system operated by the Medical Board has undergone a comprehensive overhaul in response to a perceived crisis in the physician discipline. One of the express goals was to increase the number of professionals being disciplined. (State and Consumer Services Agency, General Services, Enrolled Bill Report for S.B. 2375 (9/4/90) at p. 1.)

Nor are the cases relied upon by Dr. Landau to support her claim that the penalty here was unreasonable analogous.

In *Harris v. Alcoholic Bev. etc. Appeals Bd.* (1965) 62 Cal.2d 589, 43 Cal.Rptr. 633, 400 P.2d 745, the Alcoholic Beverages Appeals Board reversed the department's revocation of a restaurant owner's license to sell alcoholic beverages on his restaurant premises. The trial court affirmed that determination, as did the Court of Appeal. The circumstances of the revocation were that within an eight-day period several improper acts were committed, including the owner's allowing his teenage son to serve beer to minors and a waitress on one occasion served a glass of beer to an intoxicated person. The appellate court took judicial notice of a bulletin from the department containing a schedule of penalties under which the standard penalty was suspension for a total of not more than 75 days for the same or similar offenses as the one for which the department had revoked the license.

In *Magit v. Board of Medical Examiners* (1961) 57 Cal.2d 74, 17 Cal.Rptr. 488, 366 P.2d 816, the superior court overturned a license revocation after determining that Dr. Magit, the director and chief anesthesiologist of a hospital, was not guilty of unprofessional conduct in allowing unlicensed persons to administered [sic] general, spinal, and epidural anesthetics in the hospital. The appellate court found that Dr. Magit was guilty of unprofessional conduct and so reversed the superior court. However, the appellate court also concluded that under the circumstances, imposition of the maximum penalty of license revocation was an abuse of discretion. It relied upon the following considerations in so holding: "The court on sufficient evidence found that Dr. Magit acted in the utmost good faith, that Rios, Celori, and Ozbey were doctors of medicine with specialized training in anesthesiology and were highly competent anesthetists, and that on the basis of legal advice Dr. Magit was justified in assuming that the authorizing of the three unlicensed men to administer anesthetics was legal. In considering whether persons such as Rios, Celori, and Ozbey could legally administer anesthetics Dr. Magit was confronted with a question not specifically answered by the code or by any decision of our courts, and the Chalmers-Francis case had held that, in addition to licensed physicians, licensed nurses could administer anesthetics." (*Id.* at p. 88, 17 Cal.Rptr. 488, 366 P.2d 816.) Therefore, the appellate court returned the case to the board for reconsideration of the penalty to be imposed.

In the seminal case, *Skelly v. State Personnel Bd.* (1975) 15 Cal.3d 194, 124 Cal.Rptr. 14, 539 P.2d 774, a 64-year-old physician civil servant whose work was rated good to

superior, was dismissed because he had extended his lunch break beyond his allotted one hour on numerous occasions, generally by five to fifteen minutes, and had twice left the office for several hours without permission. This behavior occurred after repeated warnings and admonitions by administrative officials, who made reasonable efforts to accommodate his needs and despite a one-day suspension for similar misconduct.

The Supreme Court held dismissal to be an abuse of discretion under the circumstances. In its opinion, the court noted, "the record is devoid of evidence directly showing how petitioner's minor deviations from the prescribed time schedule adversely affected the public service. To the contrary, the undisputed evidence indicates that he more than made up for the excess lunch time by working through coffee breaks as well as on some evenings and holidays. With perhaps one or two isolated exceptions, it was not shown that his conduct in any way inconvenienced those with whom he worked or prevented him from effectively performing his duties." (*Id.* at p. 218, 124 Cal.Rptr. 14, 539 P.2d 774.) The court further relied upon findings of the hearing officer, adopted by the Medical Board that found: " 'Appellant is 64 years old, has had a long and honorable medical career and is now handicapped by serious sight and speech difficulties. Also, the Senior Medical Consultant has no complaints about appellant's work. [¶] Consideration of appellant's age, his physical problems, the lack of any apparent affect [sic] on his work and sympathy for the man and his family are all persuasive arguments in favor of finding that appellant be given just one more chance.' " (*Id.* at p. 219, 124 Cal.Rptr. 14, 539 P.2d 774.) Finally, the Supreme

Court noted that "In testifying, petitioner apologized for his conduct and promised to adhere strictly to the rules if given another opportunity to do so." (Ibid.)

The combination of these circumstances rendered dismissal an abuse of discretion.

None of these cases persuade us that the Medical Board abused its discretion here. The offenses committed here were far more serious, both in the nature of the conduct found grossly negligent and the consequences to the patients involved than those of the cited cases. Nor can Dr. Landau point to a good faith mistake or reliance upon the advice of legal counsel as in *Magit v. Board of Medical Examiners, supra,* or to anything in her testimony acknowledging her mistakes and promising to reform her conduct, if given the opportunity as in *Skelly v. State Personnel Bd., supra.*

This case appears to us more like *Dresser v. Board of Medical Quality Assurance* (1982) 130 Cal.App.3d 506, 181 Cal.Rptr. 797, wherein the Medical Board revoked the license of a psychologist found to have had sexual relations with two patients while treating them. *Dresser* did not involve a criminal offense. As in this case, the doctor argued that the penalty of license revocation was grossly disproportionate to his alleged conduct and the fact that four and one-half years had passed between the last sexual incident and the time of the Board's decision revoking his license. During this period there was no evidence that the appellant practiced psychology other than admirably and no other incident of professional

misconduct had ever been charged against him. Nevertheless, the appellate court upheld the license revocation, concluding that reasonable minds could differ as to the appropriateness of revocation in the circumstances. (*Id.* at p. 519, 181 Cal.Rptr. 797.)

Similarly, in this case we face not one, but two instances of gross negligence in the failure to adequately follow up with patients whose pathology reports indicated the existence of a possible malignant melanoma. One of those patients, S.B., ultimately died. In addition, the use of a medical technician on multiple occasions with patient J.Y. to excise moles undermines Dr. Landau's contention that revocation was based on an isolated event over an otherwise exemplary 18-year career. As in *Dresser*, the passing of a significant period of time following the unprofessional actions and the actual license revocation is certainly a factor to be considered in assessing discipline; but that factor is not determinative.

" 'The propriety of a penalty imposed by an administrative agency is a matter within its discretion and, absent a manifest abuse thereof, it will not be disturbed upon review by a trial or appellate court. [Citations.] Even if the penalty were to appear to be too harsh according to the court's evaluation, the court is not free to substitute its own discretion for that exercised by the administrative agency. [Citation.] (Fn.omitted.)' [Citations.] Even were the penalty to appear harsh to us, still we would not be free to substitute our discretion for that of the administrative body. The facts that reasonable minds might differ as to the propriety of the penalty imposed fortifies the conclusion that the administrative body acted within its discretion (*see* Code Civ. Proc., § 1094.5, subd. (e);

[citations].)" (*Dresser v. Board of Medical Quality Assurance, supra*, 130 Cal.App.3d 506, 519, 181 Cal.Rptr. 797.)

Furthermore, Dr. Landau's attitude toward the allegations and her credibility were relevant to the determination of penalty. The ALJ's assessment of Dr. Landau's credibility played an important role in his recommendation to revoke her license as made clear in his written decision: "As serious as those matters [inadequate follow-up with patients] are, of even greater concern is [Dr. Landau's] allowing a medical assistant to provide the sort of patient care which only a trained dermatologist should render. To permit a minimally trained staff member to evaluate whether or not potentially life-threatening lesions should be removed, and then to permit that person to perform the excisions necessary for removal and biopsy of those lesions, is unconscionable. For [Dr. Landau] to maintain the charade that it was she, and not the medical assistant, who performed the procedures on patient J.Y. is almost as troubling. Considering the foregoing, it is determined that protection of the public interest demands revocation of [Dr. Landau's] certificate to practice medicine." (Proposed Decision, ¶ 7, pp. 14-15, italics added.)[20]

---

[20] Following the issuance of the tentative decision, the court at the hearing on the new trial motion, held May 23, 1996, observed that it thought the penalty was "kind of big, too," but that it would also take into account the credibility issues, and Dr. Landau's refusal to admit to making a mistake.

Commenting on the penalty and the arguable appearance that it was punitive, the court asked counsel for the Board, "Is this normal?"

We reject Dr. Landau's claim the ALJ's reference to her "charade" demonstrates that the Medical Board improperly imposed the maximum penalty in retaliation for her exercise of her due process right to defend herself. Dr. Landau relies upon *In re Lewallen* (1979) 23 Cal.3d 274, 278, 152 Cal.Rptr. 528, 590 P.2d 383, wherein several remarks by the trial judge indicated that he had improperly based defendant's sentence, in part, on the defendant's rejection of a plea bargain and election to proceed to jury trial. The California Supreme Court held that, while a more severe sentence may be imposed following trial than would have been imposed had defendant pleaded guilty, the more severe sentence must be based upon legitimate factors revealed during trial or in the presentence report. (*Id.* at p. 281, 152 Cal.Rptr. 528, 590 P.2d 383.)

Dr. Landau refers us to no case outside the criminal law sentencing context which refers to this rule and we question its application to this civil discipline proceeding context. (But c.f., *Toyota of Visalia, Inc. v. New Motor Vehicle Bd.* (1987) 188 Cal.App.3d 872, 878, 233 Cal.Rptr. 708.)[21]

---

[21] "In the field of criminal law it is well established that evidence concerning an individual's postconviction conduct is relevant to his sentence and that updated information should be obtained when resentencing occurs long after the original probation officer's report was obtained. [Citations.] An automobile dealer facing the loss or suspension of his license, and thus his livelihood, is entitled to no less. This is particularly true in this type of administrative proceeding where the applicable principle is that the primary purpose of punishment is protection of the public rather than punishment of the wrongdoer. [Citation.]" (*Toyota of Visalia, Inc. v. New Motor Vehicle Bd., supra,* at p. 878, 233 Cal.Rptr. 708.)

In any event, we find the claim to be without merit in these circumstances. It is clear that a sentencing court may not increase a defendant's sentence to punish him or her for having asserted constitutional or statutory procedural rights. (*In re Lewallen, supra,* 23 Cal.3d 274, 152 Cal.Rptr. 528, 590 P.2d 383.) However, no case "imposes an absolute ban on imposition of a sentence higher than that which might have been proposed before the defendant asserted his constitutional or statutory right: There must be some showing, properly before the appellate court, that the higher sentence was imposed as punishment for exercise of the right." (*People v. Angus* (1980) 114 Cal.App.3d 973, 989-990, 171 Cal.Rptr. 5.) "In *Lewallen* the Supreme Court said: 'Thus it is clear that under appropriate circumstances a defendant may receive a more severe sentence following trial than he would have received had he pleaded guilty; the trial itself may reveal more adverse information about him than was previously known. A court may not, however, impose a sentence that conflicts with a defendant's exercise of his constitutional right to a jury trial. [Citation.]' " (*Id.* at p. 990, 171 Cal.Rptr. 5.)

Moreover, the Medical Board properly may take account of the accused doctor's attitude. (*Yellen v. Board of Medical Quality Assurance* (1985) 174 Cal.App.3d 1040, 1059, 220 Cal.Rptr. 426.) "[E]ven in a criminal proceeding, the court may take into account the defendant's attitude toward the offense and his character as evidenced by his behavior and demeanor at trial." (Ibid.)

Here, the record supports the ALJ's determination that Dr. Landau lied during her testimony about her follow up with patient S.B. and the excision of J.Y.'s moles. This "charade" in which she blamed the patients

and demonstrated neither understanding of her own wrongdoing nor remorse therefore, provides solid support for the decision to revoke her license. Unlike those criminal cases in which the defendant was able to demonstrate that the penalty was increased because he or she chose to go to trial rather than plea bargain, there is no indication here that the penalty was increased because Dr. Landau asserted her due process rights to a hearing. To the extent we may speculate that the penalty was more severe than it otherwise might have been had she testified truthfully rather than lied at the hearing, accepted responsibility for her negligence, or made some credible showing of mitigation, such increase in penalty was not the result of her exercising her due process rights to defend herself.

We believe that under the circumstances presented here, reasonable minds could differ over the appropriateness of license revocation. No more is required to find that the Medical Board acted within its discretion in revoking Dr. Landau's medical license. (E.g., *Dresser v. Board of Medical Quality Assurance, supra,* 130 Cal.App.3d 506, 519, 181 Cal.Rptr. 797.)

VI.

MISCELLANEOUS CLAIMS OF ERROR***

DISPOSITION

The appeal is dismissed. The alternative writ is discharged and the petition for writ of mandate is denied.

HAERLE and RUVOLO, JJ., concur.

*** *See* footnote *, ante.